

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. The low requires that the death certificate be executed within 24 hours after death. The low requires that the death certificate be executed within 24 hours after death.

BP

DHMH 16 50M 4/83  
(15, 4)FOR  
1- STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

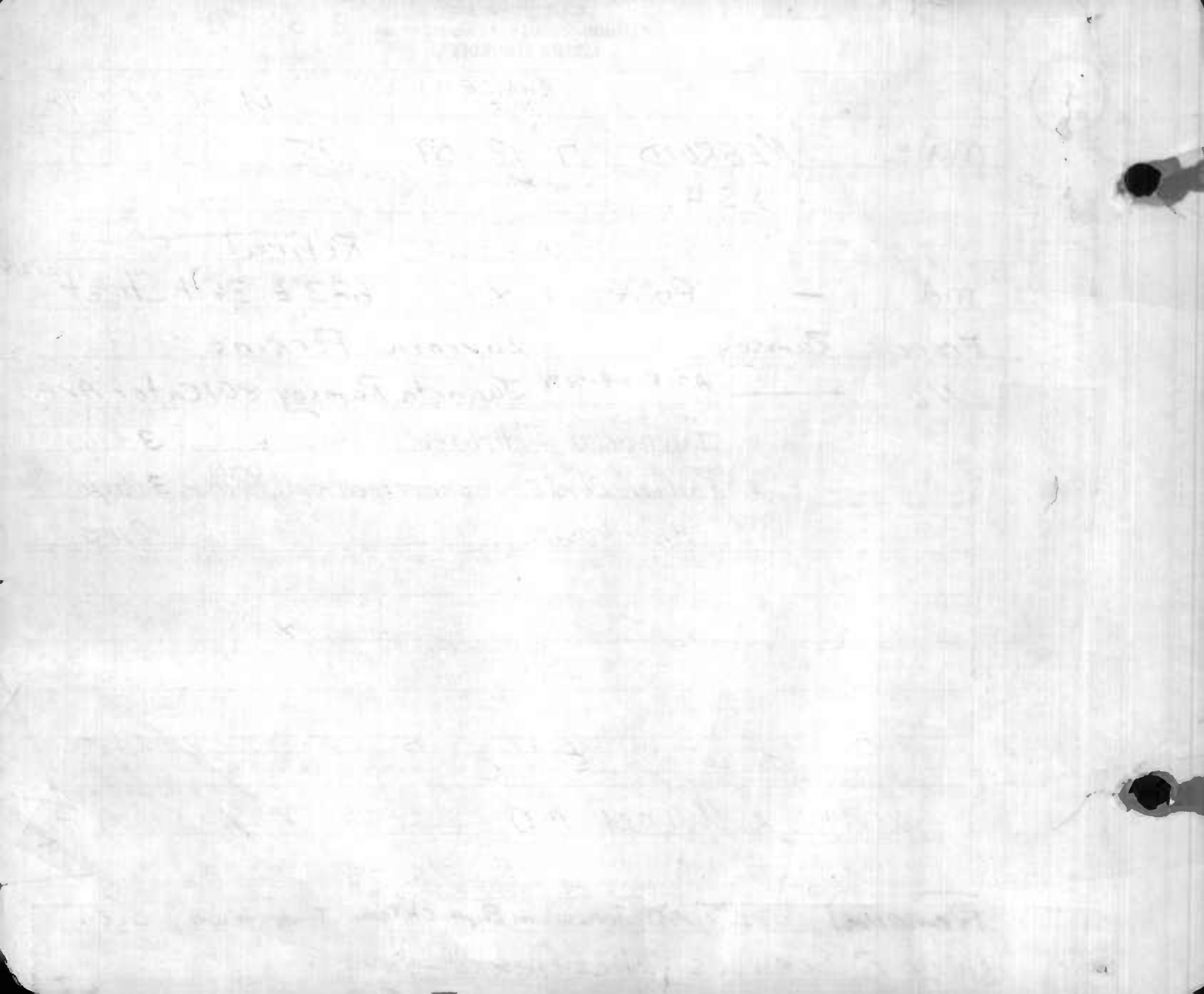
8 5 0 1 4 4 4

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <b>WILLIAM RAMSEY RAMSEY</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>01 30 85</b>		2b. HOUR <b>8:49A.M.</b>	
3. SEX <b>male</b>		4. RACE <b>NEGROID</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>7 18 09</b>		
6. AGE (IN YEARS LAST BIRTHDAY) <b>75</b> YRS.		7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>BALTIMORE</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		
8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>BALTIMORE CITY</b> MD.		10. CITY OR TOWN OF DEATH <b>BALTIMORE</b>		
11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>THE UNION MEMORIAL HOSPITAL</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Retired</b>		12b. KIND OF BUSINESS OR INDUSTRY		
13a. STATE <b>md.</b>		13b. COUNTY <b>Balto</b>		13c. CITY OR TOWN <b>Balto</b>		
14. FATHER'S NAME FIRST MIDDLE LAST <b>Francis Ramsey</b>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Luvenia Perkins</b>		16. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) <b>NO</b>		
17. SOCIAL SECURITY NO. <b>A718-09-9048</b>		18. INFORMANT ADDRESS <b>Juanita Ramsey 801 Cator Ave.</b>		19. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Increased Intracerebral Pressure</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>Thalamic Bleed &amp; extension of blood to all ventricles</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>Hypertension</b>		
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>3 days</b>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>3 days</b>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>10 yrs.</b>		
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1						
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>		
21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)		21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		
21f. LOCATION STREET CITY OR TOWN COUNTY STATE		22a. I certify that (I) (this hospital) attended the deceased from <b>Jan 27</b> , 19 <b>85</b> , to <b>Jan 30</b> , 19 <b>85</b> , that (I) (we) lost saw the deceased alive on <b>Jan 30</b> , 19 <b>85</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (I) (we) (did) (did not) view the body after death.		22b. SIGNATURE <b>Susan G. Weiner MD</b> ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		
22c. PHYSICIAN'S NAME (TYPE OR PRINT) <b>SUSAN G. WEINER, M.D.</b>		22d. ADDRESS <b>THE UNION MEMORIAL HOSPITAL</b>		22e. DATE SIGNED <b>1/30/85</b>		
23a. BURIAL, CREMATION, REMOVAL <b>Removal</b>		23b. DATE <b>Feb. 2, 1985</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Jerusalem Bury. Ch. Com.</b>		
23d. LOCATION CITY OR TOWN COUNTY STATE <b>Jonestown, S.C.</b>		24. FUNERAL DIRECTOR NAME <b>Calvin B. Scruggs</b>		25a. DATE REC'D. BY REGISTRAR <b>JAN 31 1985</b>		

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of once.

MEDICAL CERTIFICATION



TO HOSPITAL, ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be called at once.

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 5 0 1 4 4 5

1- FOR  
STATE  
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) RICHARD E. RANDOLPH SR.			2a. DATE OF DEATH MONTH DAY YEAR 1-14-85			2b. HOUR 10 <sup>05</sup> AM			
3. SEX Male		4. RACE Black		5. DATE OF BIRTH MONTH DAY YEAR 6 20 22		6. AGE (IN YEARS LAST BIRTHDAY) 62 YRS.		7. IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Md.		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE CITY MD.			
10. CITY OR TOWN OF DEATH BALTIMORE		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) VA MEDICAL CENTER BALTIMORE MD				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Md.		13b. COUNTY BALTO.		13c. CITY OR TOWN BALTO.		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 2615 E. Oliver St. 21213	
14. FATHER'S NAME FIRST MIDDLE LAST Charles Randolph				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Marie Taylor					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) Yes		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 212 16 5839		17. INFORMANT ADDRESS Richard E. Randolph, Jr 2615 E. Oliver St.					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiac Arrest</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Respiratory Arrest</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Pneumonia</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>minutes</u> <u>minutes</u> <u>2 days</u>									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I <u>Metastatic Prostate Cancer Venous Thrombosis Right Arm</u>									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET		CITY OR TOWN		COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from <u>12-27</u> 19 <u>84</u> , to <u>1-14</u> 19 <u>85</u> , that (I) (we) lost saw the deceased alive on <u>1-14</u> 19 <u>85</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE Robert Bollinger MD				DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>				22c. DATE SIGNED 1-14-85	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Robert Bollinger				22e. ADDRESS VA Hospital					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 1/19/85		23c. NAME OF CEMETERY OR CREMATORY Baltimore Cem.		23d. LOCATION CITY OR TOWN Baltimore, Md.		COUNTY STATE	
24. FUNERAL DIRECTOR NAME Wm C March F/H				ADDRESS 1101 E. North Ave.		25a. DATE REC'D. BY REGISTRAR 1-16-1985		25b. REGISTRAR'S SIGNATURE Davidson-Randall	

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STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

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FOR  
STATE  
REGISTRAR

REG. NO.

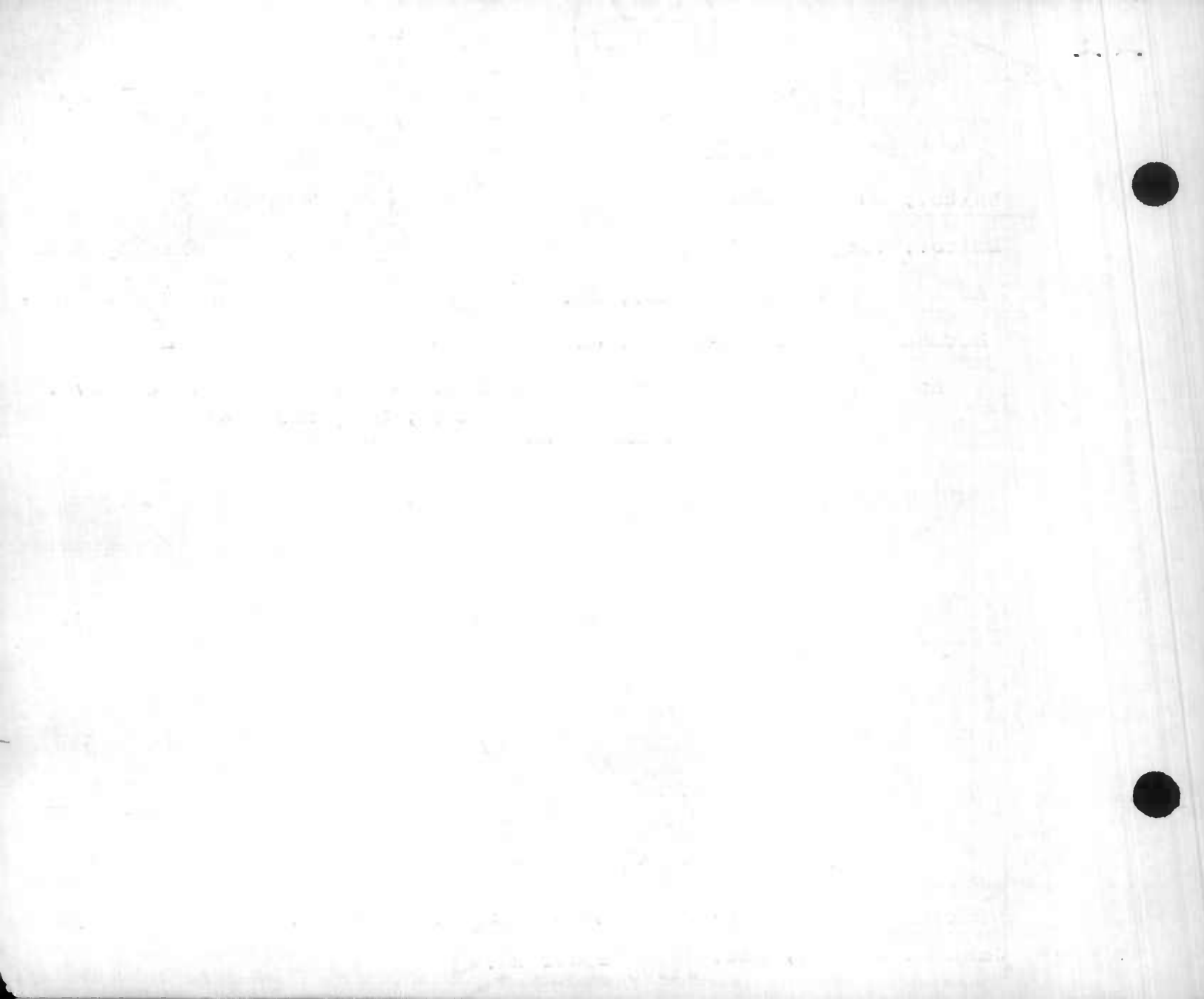
1. DECEASED NAME (TYPE OR PRINT) <b>HERMAN L RAPPOLT III</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>01 09 85</b>		2b. HOUR OF M <b>2A</b>				
1. SEX <b>MALE</b>		4. RACE <b>White</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>06 15 48</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>36</b> YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Balto., MD</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>BALTIMORE CITY</b> MD.			
10. CITY OR TOWN OF DEATH <b>Balto., City</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Good Samaritan Hospital</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Retired</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Whiskey Sales</b>	
13a. STATE <b>MD</b>		13b. COUNTY <b>Balto.</b>		13c. CITY OR TOWN <b>Balto., Co.</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
14. FATHER'S NAME FIRST MIDDLE LAST <b>Herman L. Rappolt, Jr.</b>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Selma Haupt</b>		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) <b>no</b>					
16b. SOCIAL SECURITY NO. <b>214-26-4664</b>		17. INFORMANT ADDRESS <b>Oscar F. Haupt, 6409 Laurelton Ave. Baltimore, Maryland 21214</b>							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>CARDIAC ARREST</b> DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a):									
19a. DATE OF OPERATION <b>1-8-85</b>		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>ABDOMINAL ANEURYSM</b>				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from <b>12-26</b> , 19 <b>84</b> , to <b>1-9</b> , 19 <b>85</b> , that (I) (we) last saw the deceased alive on <b>1-9-</b> 19 <b>85</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <b>Kwang N. Kim</b>		DEGREE <b>MD</b>		ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>				22c. DATE SIGNED <b>1-9-85</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>KWANG N. KIM</b>		22e. ADDRESS <b>5601 LOCH RAVEN BLVD</b>				22f. CITY OR TOWN <b>BALTO.</b> COUNTY STATE <b>MD</b>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>1-12-85</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Balto. Cemetery</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>BALTO. MD</b>			
24. FUNERAL DIRECTOR NAME <b>John C. Miller, Inc. 6415 Belair Rd. 21206</b>				25a. DATE REC'D. BY REGISTRAR <b>JAN 14 1985</b>		25b. REGISTRAR'S SIGNATURE <b>John Davidson</b>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 1 and 2 should be filed with 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of same.

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# DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH

01447  
REG. NO.

1- STATE REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) <span style="float: right;">FIRST MIDDLE LAST</span> <div style="display: flex; justify-content: space-between;"><span>William</span><span>G.</span><span>Raub</span></div>				2a. DATE KNOWN OF DEATH ESTIMATED <input checked="" type="checkbox"/> MONTH DAY YEAR 1-23 1985		2b. HOUR M 7:26 P. M	
3. SEX Male	4. RACE White	5. DATE OF BIRTH MONTH DAY YEAR Aug 31 1914	6. AGE (IN YEARS) LAST BIRTHDAY 70 YRS.	IF UNDER 1 YR. MONTHS DAYS HOURS MIN	IF UNDER 24 HRS.	2c. DATE PRONOUNCED DEAD MONTH DAY YEAR 1-23 1985	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Md.		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City, MD	
10. CITY OR TOWN OF DEATH Baltimore		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 141 N. Patterson Park Avenue				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)	
12b. KIND OF BUSINESS OR INDUSTRY							
13. USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)							
13a. STATE Md.		13b. COUNTY		13c. CITY OR TOWN Baltimore		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
13e. STREET ADDRESS 141 N. Patterson Pk. Ave.							
14. FATHER'S NAME FIRST MIDDLE LAST Frank G. Raub				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Anna J. -----			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES)		17. INFORMANT ADDRESS			
NO		218-10-5839 1		Raymond Raub 141 N. Patterson Pk. Ave.			

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Arteriosclerotic Cardiovascular Disease</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost. } (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
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PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).

19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	

22a. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from <u>Natural causes</u> <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .					
ACTUAL SIGNATURE <u>Dennis F. Smyth</u> M.D. Assistant				DATE SIGNED 1-24-85	
EXAMINER'S NAME (TYPE OR PRINT) <u>Dennis F. Smyth, M.D.</u>				ADDRESS <u>111 Penn St., Baltimore, Md. 21201</u>	

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		23b. DATE <u>1-26-1985</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Moreland Memorial</u>		23d. LOCATION CITY OR TOWN COUNTY STATE <u>Balto. Md.</u>	
24. FUNERAL DIRECTOR NAME ADDRESS <u>John M. Weber &amp; Sons Inc. 401 S. Chester St.</u>				25a. DATE REC'D. BY REGISTRAR <u>JAN 28 1985</u>		25b. REGISTRAR'S SIGNATURE <u>Lelia Davidson-Randall</u>	

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM-3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

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STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 5 0 1 4 4 8

1- FOR  
STATE  
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) BABY BOY REBERT			2a. DATE OF DEATH MONTH DAY YEAR JAN. 5, 1985			2b. HOUR 6:55 P.M.			
3. SEX MALE		4. RACE WHITE		5. DATE OF BIRTH MONTH DAY YEAR JAN 4, 1985		6. AGE (IN YEARS LAST BIRTHDAY) YRS. MONTHS DAYS MIN. 1		IF UNDER 1 YEAR IF UNDER 24 HRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MARYLAND		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE CITY MD.			
10. CITY OR TOWN OF DEATH BALTIMORE		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) MERCY HOSPITAL		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) -		12b. KIND OF BUSINESS OR INDUSTRY			
13a. STATE MARYLAND		13b. COUNTY CAROL		13c. CITY OR TOWN WESTMINSTER		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 1023 LUCABAUGH RD.	
14. FATHER'S NAME FIRST MIDDLE LAST GERALD NEAL REBERT		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST LILLIAN MARIA BROWN		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS			
18a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		18b. SOCIAL SECURITY NO.		18c. SOCIAL SECURITY NO.		18d. SOCIAL SECURITY NO.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CARDIORESPIRATORY FAILURE</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>SEVERE HYALINE MEMBRANE DISEASE</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>R/O HYPOPLASTIC LUNGS</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) <u>Renal failure</u>									
9a. DATE OF OPERATION		9b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from <u>Jan. 4, 1985</u> , to <u>Jan. 5, 1985</u> , that (I) (we) last saw the deceased alive on <u>Jan. 5, 1985</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <u>Isabelita G. Frattarola</u>						DEGREE MD		22c. DATE SIGNED	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) ISABELITA G. FRATTAROLA						22e. ADDRESS MERCY HOSPITAL BALTIMORE, MARYLAND			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Removal		23b. DATE 1/10/85		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN COUNTY STATE			
24. FUNERAL DIRECTOR NAME Anatomy Board						ADDRESS Balto., Md.		25a. DATE REC'D. BY REGISTRAR JAN 17 1985	
						25b. REGISTRAR'S SIGNATURE John Davidson			



CHIEFMAN

BOX COLLECTOR



STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 5 0 1 4 4 9

1- FOR  
STATE  
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT)			2a. DATE OF DEATH			2b. HOUR		
FIRST MIDDLE LAST Arnold Redman			MONTH DAY YEAR 1 21 85			107 A M		
3. SEX	4. RACE	5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YEAR		IF UNDER 24 HRS
Male	White	MONTH DAY YEAR 5 20 14		70 YRS.		MONTHS DAYS		HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH			
Pa.	U. S. A.				Baltimore City MD			
10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY			
Balto.	St. Agnes Hospital		White Towers-Rest.		Manager			
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)			13d. INSIDE CITY LIMITS?		13e. STREET ADDRESS / ZIP CODE			
13a. STATE 13b. COUNTY 13c. CITY OR TOWN Md. Balto.			YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		Balto., Md. 960 Masefield Rd. #21207			
14. FATHER'S NAME FIRST MIDDLE LAST George W.			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Annie A. Jensen					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) Yes			16b. SOCIAL SECURITY NO. 518-18-1559-A		17. INFORMANT ADDRESS 960 Masefield Rd. - Balto., Md. Mrs. Catherine E. Redman #21207			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>pulmonary edema</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>congestive heart failure</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>sp. infarction + alcohol cardiomyopathy</u>								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: (a)								
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
						YES <input type="checkbox"/> NO <input type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) lost saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.								
22b. SIGNATURE <u>A. Maciulis</u>						DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED
22d. PHYSICIAN'S NAME (TYPE OR PRINT) A. MACIULIS			22e. ADDRESS					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE 1-24-85		23c. NAME OF CEMETERY OR CREMATORY Garrison Forest Vets. Cem.		23d. LOCATION CITY OR TOWN COUNTY STATE Owings Mills Md	
24. FUNERAL DIRECTOR G. Treman Schwab			25a. DATE REC'D. BY REGISTRAR JAN 22 1985			25b. REGISTRAR'S SIGNATURE <u>F. J. Davidson</u>		

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.



STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. FOR  
STATE  
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) David H. Redwin			2a. DATE OF DEATH MONTH DAY YEAR 1 23 85		2b. HOUR M
3. SEX Male	4. RACE Black	5. DATE OF BIRTH MONTH DAY YEAR 12 15 00		6. AGE (IN YEARS LAST BIRTHDAY) 84 YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Jamaica	7b. CITIZEN OF WHAT COUNTRY? West British Indies	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Balto. City MD.	
10. CITY OR TOWN OF DEATH Balto.	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 4004 Woodridge Rd.		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY
13a. STATE Md.			13b. COUNTY	13c. CITY OR TOWN Balto.	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
14. FATHER'S NAME FIRST MIDDLE LAST UNK			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST UNK		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 216-03-6695		17. INFORMANT ADDRESS Dallaree Redwin 4004 Woodridge Rd.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>RESPIRATORY ARREST</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (b), stating the underlying cause last. (b) <u>METASTATIC CANCER of</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>THE PROSTATE</u>					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (d)					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from <u>MARCH</u> 19 <u>83</u> to <u>JAN 23</u> 19 <u>85</u> , that (I) (we) lost saw the deceased alive or above (I) (we) (did) (did not) view the body after death. <u>NOVEMBER</u> 19 <u>84</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated					
22b. SIGNATURE Winthrop C. Davis, MD DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>				22c. DATE SIGNED 1/24/85	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Winthrop C. Davis, MD		22e. ADDRESS 700 WASHINGTON BLVD.			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 1/26/85		23c. NAME OF CEMETERY OR CREMATORY Eastview Cem.	
23d. LOCATION CITY OR TOWN COUNTY STATE Balto. Md.		23e. DATE REC'D. BY REGISTRAR JAN 25 1985			
24. FUNERAL DIRECTOR NAME Wm. C. March F/H 1101 E. North Ave.		25b. REGISTRAR'S SIGNATURE John S. [Signature]			

BP

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 2 and 3 should be detached for use as the burial/transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

RECEIVED  
JUL 11 1964  
U.S. AIR FORCE  
OFFICE OF THE  
JOINT CHIEFS OF STAFF  
WASHINGTON, D.C.

1



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 1 and 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				REG. NO.			
1. FOR STATE REGISTRAR				2a. DATE OF DEATH			
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST HATTIE REED				MONTH DAY YEAR JAN 18 85		2b. HOUR 152 AM	
3. SEX FEMALE		4. RACE BLACK		5. DATE OF BIRTH MONTH DAY YEAR 08 24 00		6. AGE (IN YEARS LAST BIRTHDAY) 84 YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) SOUTH CAROLINA		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE CITY MD.	
10. CITY OR TOWN OF DEATH BALTIMORE		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) SINAI HOSPITAL OF BALTIMORE				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)	
12b. KIND OF BUSINESS OR INDUSTRY							
13a. STATE MARYLAND				13b. COUNTY BALTIMORE		13c. CITY OR TOWN BALTIMORE	
13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>				13e. STREET ADDRESS / ZIP CODE 4300 LIBERTY HEIGHTS AVE 21207			
14. FATHER'S NAME FIRST MIDDLE LAST JESSIE Agnew				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST SARAH Harris			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		16b. SOCIAL SECURITY NO. NA		17. INFORMANT ADDRESS Lucille Ziglier 3908 Liberty Heights			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CARDIAC ARREST</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>MYOCARDIAL ISCHEMIA</u> DUE TO, OR AS A CONSEQUENCE OF (c)							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 11a <u>ATRIAL FIBRILLATION, PNEUMONIA, CONGESTIVE HEART FAILURE</u>							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18. PART I OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <u>JANUARY 9, 19 85</u> , to <u>JANUARY 18, 19 85</u> , that (I) (we) last saw the deceased alive on <u>JANUARY 18, 19 85</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE David Lee Schreiberman MD				DEGREE MD		22c. DATE SIGNED 1/18/85	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) DAVID LEE SCHREIBMAN				22e. ADDRESS SINAI HOSPITAL - BELVEDERE AT GREENSPRING			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 1/22/85		23c. NAME OF CEMETERY OR CREMATORY Arbutus mem.		23d. LOCATION CITY OR TOWN COUNTY STATE Balto. Co. MD	
24. FUNERAL DIRECTOR NAME Wm. C. March F/H 1101 E. North Ave.				25a. DATE REC'D. BY REGISTRAR JAN 22 1985		25b. REGISTRAR'S SIGNATURE C. F. Anderson-Randall	





STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

01452

1. DECEASED NAME (TYPE OR PRINT)			FIRST MIDDLE LAST			2a. DATE KNOWN OF DEATH			MONTH DAY YEAR			2b. HOUR		
DANIEL LEE REEDY						X			1-11-85			M		
3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (IN YEARS)	IF UNDER 1 YR.	IF UNDER 24 HRS.	2c. DATE PRONOUNCED DEAD			MONTH DAY YEAR			2d. HOUR		
MALE	CAUCASIAN	03 02 54	30 YRS.			1-11-85			19			7PM		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)			7b. CITIZEN OF WHAT COUNTRY?			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH			MD		
MARYLAND			USA						Baltimore City					
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY					
Baltimore			University Hospital STU			UNEMPLOYED			-----					
13a. STATE			13b. COUNTY			13c. CITY OR TOWN			13d. INSIDE CITY LIMITS?			13e. STREET ADDRESS		
MARYLAND			BALTIMORE			BALTIMORE			YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			6212 HOLABIRD AVE. 21220		
14. FATHER'S NAME			15. MOTHER'S MAIDEN NAME			16a. WAS DECEASED EVER IN U.S. ARMED FORCES?			16b. SOCIAL SECURITY NO.			17. INFORMANT ADDRESS		
RICHARD			DOLORES			NO			218608827			DOLORES HUSELTON 207 MIDDLEWAY		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)			PART 1 DEATH WAS CAUSED BY:			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH								
8147			IMMEDIATE CAUSE (a) Multiple injuries											
			DUE TO, OR AS A CONSEQUENCE OF											
			(b)											
			DUE TO, OR AS A CONSEQUENCE OF											
			(c)											
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).														
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?			20. AUTOPSY?			YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>					
21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			21b. TIME OF INJURY			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)								
			11:45 PM 1-9-85			pedestrian struck by a vehicle								
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)			21f. LOCATION								
			hwy.			Rt. 40 Nr. Lorraine Ave. Rosedale, Maryland								
22a. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .														
ACTUAL SIGNATURE			TITLE (SPECIFY)			DATE SIGNED								
			M.D. Assistant			1-12-85								
EXAMINER'S NAME (TYPE OR PRINT)			ADDRESS											
Gregory R.K. auffman, M.D.			111 Penn Street											
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)			23b. DATE			23c. NAME OF CEMETERY OR CREMATORY			23d. LOCATION			23e. COUNTY		
BURIAL			01/14/85			OAKLAWN CEMETERY			BALTO.			BALTO. MD.		
24. FUNERAL DIRECTOR (NAME)			ADDRESS			25a. DATE REC'D. BY REGISTRAR			25b. REGISTRAR'S SIGNATURE					
J. L. H. H.			1211 Chesaco Ave.			JAN 14 1985			J. L. H. H.					

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 5. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL, TRANSIT PERMIT, PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

07/84  
25M

BP  
DHMH - 17  
(VR A15 ME (5))

NOV 20 1964

RECEIVED

NOV 20 1964

NOV 20 1964



DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

**MEDICAL CERTIFICATION**

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

07/B4  
25M

DHMH - 17  
(VR A15 ME (5))

1914 NOV 10 10 50 AM



111

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after the death. The certificate may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the medical examiner, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

DHMH - 16 50M 1/81  
(VRA 15, 4)

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. FOR  
STATE  
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <b>Louisa E. Reeves</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>1 17 85</b>		2b. HOUR M <b>8 PM</b>	
3. SEX <b>Female</b>		4. RACE <b>Black</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>6 23 92</b>		6. AGE (IN YEARS (LAST BIRTHDAY)) <b>92</b> YRS
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>S. Carolina</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Baltimore City, MD</b>
10. CITY OR TOWN OF DEATH <b>Baltimore</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF UNDER 24 HOURS OF RESIDENCE BEFORE DEATH) <b>Jennings Memorial Home 1000 S. Caton Ave. 21229</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY
13a. STATE <b>Maryland</b>			13b. COUNTY		13c. CITY OR TOWN <b>Baltimore</b>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>Walter Reeves</b>			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Martha</b>			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) <b>NO</b>			16b. SOCIAL SECURITY NO. <b>213-12-8220</b>		17. INFORMANT ADDRESS <b>A Sister Brenda Motto 1026 Brentwood Ave.</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Arteriosclerotic cerebrovasc. dis</b> DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last						APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>yes</b>
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 11a						
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)		
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE		
22a. I certify that (I) (the hospital) attended the deceased from <b>9-23, 1983</b> to <b>1-17, 1985</b> , that (I) (we) last saw the deceased alive on <b>1-17, 1985</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.						
22b. SIGNATURE <b>L. G. GALLAGHER, M.D.</b>				DEGREE <b>MD</b>		22c. DATE SIGNED <b>1-18-85</b>
22b. PHYSICIAN'S NAME (TYPE OR PRINT) <b>L. G. GALLAGHER, M.D.</b>				22c. ADDRESS <b>STAGNES MED CTR, Balto 21229</b>		
23a. BURIAL, CREMATION, REMOVAL <b>BURIAL</b>		23b. DATE <b>1/22/85</b>		23c. NAME OF CEMETERY OR CREMATORY <b>New Cathedral Cem</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Baltimore, Md.</b>
24. FUNERAL DIRECTOR NAME ADDRESS <b>Wm C March F/H Inc. 1101 E North Avenue</b>				25a. DATE REC'D. BY REGISTRAR <b>JAN 21 1985</b>		
				25b. REGISTRAR'S SIGNATURE <b>John Davidson</b>		

MEDICAL CERTIFICATION



INSTR 80



STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

FOR  
1 - STATE  
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) <b>Charles Benjamin Reinhardt Sr.</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>1-30-85</b>			2b. HOUR M <b>AM</b>		
3. SEX <b>Male</b>		4. RACE <b>White</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>1-4-1892</b>		6. AGE (IN YEARS LAST BIRTHDAY) YRS. MONTHS DAYS HOURS MIN. <b>93</b>		
7a. BIRTHPLACE (STATE OR FOREIGN) <b>Balto. Md.</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Baltimore City</b> MD.		
10. CITY OR TOWN OF DEATH <b>Balto. Md.</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>6510 Rosemont Ave. -21206</b>			12a. USUAL OCCUPATION (TYPE OF WORK FORMER OR WORKING LIFE) <b>B &amp; O R.R.</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Retired</b>	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE <b>Md.</b> 13b. COUNTY <b>Baltimore</b> 13c. CITY OR TOWN <b>Baltimore</b> 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> 13e. STREET ADDRESS / ZIP CODE <b>6510 Rosemont Ave. -21206</b>								
14. FATHER'S NAME FIRST MIDDLE LAST <b>Wilhelm Reinhardt</b>				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Jennie Mengersen</b>				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>Yes</b>		16b. SOCIAL SECURITY NO. (IF NOT IN SUCH FACILITY, GIVE WAR OR DATES) <b>705-05-6168</b>		17. INFORMANT ADDRESS <b>Mrs. Caroline E. Reinhardt 6510 Rosemont Ave. 21206</b>				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>ACUTE PEPTIC ULCER DISEASE WITH BLEEDING</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: (b) <b>ABDOMINAL ANEURYSM</b> (c) <b>H. AS. CVD. AND SEVERE COPD</b> DUE TO, OR AS A CONSEQUENCE OF DUE TO, OR AS A CONSEQUENCE OF APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH								
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: (a) <b>ANGINA PECTORIS AND ARYTHMIA</b>								
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)				
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE				
22a. I certify that (I) (this hospital) attended the deceased from <b>APRIL</b> , 19 <b>69</b> , to <b>JAN-</b> , 19 <b>85</b> , that (I) (we) last saw the deceased alive on <b>1-28-</b> , 19 <b>85</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.								
22b. SIGNATURE <b>G.R. Sadjadi, M.D.</b>				DEGREE <b>ATTENDING PHYSICIAN</b> <input checked="" type="checkbox"/> <b>MEDICAL DIRECTOR</b> <input type="checkbox"/> <b>STAFF PHYSICIAN</b> <input type="checkbox"/>		22c. DATE SIGNED <b>1-31-85</b>		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>G. R. SADJADI, M.D.</b>				22e. ADDRESS <b>6331 BELAIR RD BALTIMORE, MD 21206</b>				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>2-2-85</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Gardens of Faith Cem</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Balto. Md.</b>		
24. FUNERAL DIRECTOR NAME <b>John C. Miller Inc-6415 Belair Rd.-21206</b>				25. DATE REC'D. BY REGISTRAR 25b. REGISTRAR'S SIGNATURE <b>FEB 4 1985 John Davidson-Randall</b>				

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

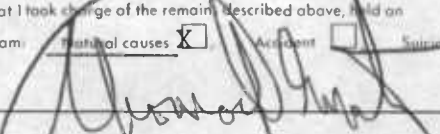
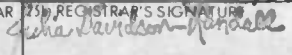
STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH									
1. FOR STATE REGISTRAR <b>Marcelo Consuelo Reposar</b>									
1 DECEASED NAME (TYPE OR PRINT) <b>MARCELO Consuelo REPOSAR</b>						2a DATE OF DEATH MONTH <b>1</b> DAY <b>1</b> YEAR <b>85</b> HOUR <b>5:40</b> P.M.			
3 SEX <b>MALE</b>		4 RACE <b>Filipino</b>		5 DATE OF BIRTH MONTH <b>10</b> DAY <b>28</b> YEAR <b>97</b>		6 AGE (IN YEARS LAST BIRTHDAY) <b>87</b> YRS.		7 IF UNDER 1 YEAR MONTHS <b>1</b> DAYS <b>1</b> HOURS <b>40</b> MIN.	
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>PHILIPPINES</b>		7b CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH <b>Baltimore City,</b> MD.			
10 CITY OR TOWN OF DEATH <b>Baltimore</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Lutheran Hospital</b>				12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Chief Cook</b>		12b KIND OF BUSINESS OR INDUSTRY <b>Maritime Ser.</b>	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)									
13a STATE <b>Maryland</b>		13b COUNTY <b>---</b>		13c CITY OR TOWN <b>Baltimore</b>		13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e STREET ADDRESS <b>1615 N. Bentalou St. 21216</b>	
14 FATHER'S NAME FIRST <b>Jose</b> MIDDLE <b>Reposar</b> LAST <b>Reposar</b>				15 MOTHER'S MAIDEN NAME FIRST <b>Rosa</b> MIDDLE <b>Consuelo</b> LAST <b>Consuelo</b>					
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>No</b>		16b SOCIAL SECURITY NO. <b>213.12.6906</b>		17 INFORMANT ADDRESS <b>Mildred L. Reposar (same as 13e)</b>					
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Myocardial Infarction</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>Atherosclerosis</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>---</b>									
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)									
19a DATE OF OPERATION		19b CONDITION FOR WHICH OPERATION WAS PERFORMED				20a AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>		21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f LOCATION STREET CITY OR TOWN COUNTY STATE					
22a I certify that (I) (this hospital) attended the deceased from <b>did at 5:40pm on 1/1/85</b> at (I) (we) last saw the deceased alive on <b>19</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (for use by medical examiner to view the body after death)									
22b SIGNATURE <b>[Signature]</b>				DEGREE <b>---</b>				22c DATE SIGNED <b>1/1/85</b>	
22d PHYSICIAN'S NAME (TYPE OR PRINT) <b>M. SINGH</b>				22e ADDRESS <b>Lutheran Hosp, Baltimore</b>					
23a BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Cremation</b>		23b DATE <b>1/3/1985</b>		23c NAME OF CEMETERY OR CREMATORY <b>Green Mount Crematory</b>		23d LOCATION CITY OR TOWN COUNTY STATE <b>Baltimore, MD</b>		23e DATE REC'D. BY REGISTRAR <b>JAN 7 1985</b>	
24 FUNERAL DIRECTOR NAME <b>Walter Brooks Bradley, Inc. Balto., MD 21222</b>				25 REGISTRAR'S SIGNATURE <b>[Signature]</b>					

BP



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										REG. NO. 01457			
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST William Edward REUTHER										2a. DATE KNOWN OF DEATH <input type="checkbox"/> MONTH DAY YEAR 1 5 19 85		2b. HOUR M	
3. SEX Male		4. RACE Cauc.		5. DATE OF BIRTH MONTH DAY YEAR Feb 16, 1930		6. AGE (IN YEARS) LAST BIRTHDAY 54 YRS.		7. IF UNDER 24 HRS. MONTHS DAYS HOURS MIN		2c. DATE PRONOUNCED DEAD 1 5 19 85		2d. HOUR 10:15 a M	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Md		7b. CITIZEN OF WHAT COUNTRY? U. S. A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City, MD							
10. CITY OR TOWN OF DEATH Baltimore		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 3309 E. Baltimore Street				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Roofers		12b. KIND OF BUSINESS OR INDUSTRY Roofing Comp					
13a. STATE Md		13b. COUNTY		13c. CITY OR TOWN Balto.		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 3309 E. Baltimore St.					
14. FATHER'S NAME FIRST MIDDLE LAST Louis Reuther				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Bennett									
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) Yes		(IF YES, GIVE WAR OR DATES) Korean War		16b. SOCIAL SECURITY NO. 220-20-2353		17. INFORMANT Florence L. Zelisse		ADDRESS 3309 E. Balto St. 21224					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cirrhosis</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)													
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: <u>Natural causes</u> <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .													
ACTUAL SIGNATURE 				TITLE (SPECIFY) Acting Chief				DATE SIGNED 1/5/85					
EXAMINER'S NAME (TYPE OR PRINT) Thomas D. Smith, M.D.				ADDRESS 111 Pern St. Balto., MD.									
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 1-8-1985		23c. NAME OF CEMETERY OR CREMATORY Oaklawn Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Balto. MD.							
24. FUNERAL DIRECTOR NAME Joseph N. ZANNING JR.				ADDRESS 263 S. 41224		25a. DATE REC'D. BY REGISTRAR JAN 8 1985		25b. REGISTRAR'S SIGNATURE 					



POST OFFICE BOX

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**STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH**

0 1 4 5 8  
REG. NO.

1- STATE REGISTRAR		2a. DATE KNOWN OF DEATH		2b. DATE ESTI MATED		2c. MONTH DAY YEAR		2d. HOUR	
1. DECEASED NAME (TYPE OR PRINT)		3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS)	
FRISK		Male		White		7. MONTH DAY YEAR		76 YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED		9. BALTIMORE CITY OR COUNTY OF DEATH			
Pennsylvania		U.S.A.		WIDOWED		Baltimore City			
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY			
Baltimore		University Hospital (STU)		Employee - Dundalk		Florist			
13a. STATE		13b. CITY OR TOWN		13c. STREET ADDRESS		13d. INSIDE CITY LIMITS?			
Maryland		Dundalk		6614 Woods Parkway		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		21222	
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME		16a. WAS DECEASED EVER IN U.S. ARMED FORCES?		16b. SOCIAL SECURITY NO.		17. INFORMANT	
Not Known		Not Known		(YES, NO, OR UNKNOWN)		220-12-7060 A		August H. Koch, Jr., Balto. MD 21222	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)		19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?		20. AUTOPSY?			
PART I DEATH WAS CAUSED BY:						YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
8147 IMMEDIATE CAUSE (a) Multiple injuries									
DUE TO, OR AS A CONSEQUENCE OF									
Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost.									
(b) DUE TO, OR AS A CONSEQUENCE OF									
(c)									
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1									
21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)					
5:53 P.M. 1-16- 1985		Pedestrian struck by auto.							
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION		CITY OR TOWN		COUNTY STATE	
road		German Hill Rd. & 51st St., Balto.						Md.	
22a. I certify that I took charge of the remains described above, held an autopsy <input checked="" type="checkbox"/> . Inspection <input type="checkbox"/> . Inquiry <input type="checkbox"/> . and in my opinion death resulted from		Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> (Suicide <input type="checkbox"/> . Homicide <input type="checkbox"/> . Undetermined manner <input type="checkbox"/> .							
ACTUAL SIGNATURE		TITLE (SPECIFY)		DATE SIGNED					
Dennis F. Smyth, M.D.		Assistant		1-17-85					
EXAMINER'S NAME (TYPE OR PRINT)		ADDRESS							
Dennis F. Smyth, M.D.		111 Penn St., Balto., Md. 21201							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION		CITY OR TOWN COUNTY STATE	
Burial		1/22/85		Sacred Heart of Mary		Dundalk, Baltimore, Maryland			
24. FUNERAL DIRECTOR NAME		25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE					
Duda-Ruck, Inc.		JAN 23 1985							
7922 Wise Avenue, Dundalk, MD 21222									

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 24 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

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WIKI-THIRD

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STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

FOR  
1 - STATE  
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) <b>Sadie Rhodes</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>January 16, 1985</b>			2b. HOUR P M <b>1:26 P</b>				
3. SEX <b>Female</b>	4. RACE <b>Black</b>	5. DATE OF BIRTH MONTH DAY YEAR <b>7 15 26</b>	6. AGE (IN YEARS LAST BIRTHDAY) <b>58</b> YRS.			7. IF UNDER 1 YEAR MONTHS DAYS <b>0 0</b>		8. IF UNDER 24 HRS. HOURS MIN. <b>0 0</b>		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>North CARO.</b>	7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Baltimore City</b> MD.					
10. CITY OR TOWN OF DEATH <b>Baltimore</b>	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Maryland General Hospital</b>			12a. USUAL OCCUPATION (LAST WORK FOR MOST OF WORKING LIFE) <b>Domestic</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>—</b>				
13a. STATE <b>MD.</b>			13b. COUNTY <b>BALTO.</b>		13c. CITY OR TOWN <b>BALTO.</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE <b>2022 McCulloh St. 21217</b>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>— — —</b>			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>— — —</b>							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>NO</b>			16b. SOCIAL SECURITY NO. <b>213-52-0010</b>		17. INFORMANT ADDRESS <b>Geraldine Morgan 2022 McCulloh St.</b>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Respiratory Arrest</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>Cerebrovascular Accident</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>—</b>									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>—</b>	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: (a) <b>Chronic Atrial Fibrillation, Hypertension</b>										
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <b>January 16, 1985</b> to <b>January 16, 1985</b> , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on <b>January 16, 1985</b> , and that in <input checked="" type="checkbox"/> (my) <input checked="" type="checkbox"/> (our) opinion death occurred on the date and hour and from the causes stated above, <input checked="" type="checkbox"/> (we) <input checked="" type="checkbox"/> (I) <input checked="" type="checkbox"/> (we) did <input checked="" type="checkbox"/> (I) <input checked="" type="checkbox"/> (we) view the body after death.										
22b. SIGNATURE <b>Charles C. Ridley M.D.</b>			DEGREE <b>M.D.</b>			ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22c. DATE SIGNED <b>1/17/85</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>Charles Ridley, M.D.</b>			22e. ADDRESS <b>c/o Maryland General Hospital</b>							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>			23b. DATE <b>1/19/85</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Mt. Zion</b>			23d. LOCATION CITY OR TOWN COUNTY STATE <b>BALTO. MD.</b>		
24. FUNERAL DIRECTOR NAME <b>Wm C. Brown Comm. F.H.</b>			ADDRESS <b>1206 W. North Ave</b>			25a. DATE REC'D. BY REGISTRAR <b>JAN 18 1985</b>		25b. REGISTRAR'S SIGNATURE <b>Davidson-Randall</b>		

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

100% COTTON FIBER

POWDER



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified and page 3 must be completed.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				REG. NO.			
1. DECEASED NAME (TYPE OR PRINT) <b>Florence B RICE</b>				2a. DATE OF DEATH MONTH DAY YEAR 1-23-85 2b. HOUR 4:20 PM			
3 SEX <b>FEMALE</b>		4 RACE <b>BLACK</b>		5. DATE OF BIRTH MONTH DAY YEAR 12 9 44		6. AGE (IN YEARS LAST BIRTHDAY) 40 YRS	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>N.C.</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH <b>Baltimore City</b> MD.	
10 CITY OR TOWN OF DEATH <b>Baltimore</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>John Deaton W/H</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY	
13a. STATE <b>MD</b>		13b. COUNTY		13c. CITY OR TOWN <b>Baltimore</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
13e. STREET ADDRESS / ZIP CODE <b>1637 Thomas Ave. 21216</b>		14 FATHER'S NAME FIRST MIDDLE LAST <b>Herbert P. Rice</b>		15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Lattie Criss</b>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>NO</b>		16b. SOCIAL SECURITY NO. <b>N/A</b>		17 INFORMANT ADDRESS <b>Lattie Rice 1637 Thomas Ave.</b>			
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Sepsis</b> DUE TO, OR AS A COMPLICATION OF (b) <b>Pneumonia</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) <b>Comp to metabolic encephalopathy 2 months</b> PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: (d)				APPROPRIATE INTERVAL BETWEEN DEATH AND DEATH CERTIFICATE			
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (this hospital) attended the deceased from 1/23/85 to 1/23/85, that (we) last saw the deceased alive on 1/23/85, and that in (our) opinion death occurred on the date and hour and from the causes stated above. (we) (did) (did not) view the body after death.				22b. SIGNATURE <b>Dr. Gladen</b> DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <b>1/29/85</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>1/28/85</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Cedar Hill Cem.</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Anne Arundel Co. MD</b>	
24 FUNERAL DIRECTOR NAME <b>Wm. C. March R/H</b> ADDRESS <b>1101 E. North Ave</b>				25a. DATE RECEIVED BY REGISTRAR <b>JAN 25 1985</b> 25b. REGISTRAR'S SIGNATURE <b>[Signature]</b>			

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DATE: 1915

REPORT OF

NO. 1000

George D. ...

...

...



STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

1- FOR  
STATE  
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) <b>KING</b>			2a. DATE KNOWN OF DEATH ESTIMATED <input checked="" type="checkbox"/> MONTH DAY YEAR <b>1-13-85</b>			2b. HOUR M <b>10:40</b>	
3. SEX <b>Male</b>	4. RACE <b>Black</b>	5. DATE OF BIRTH MONTH DAY YEAR <b>62</b> YRS.	6. AGE (IN YEARS) LAST BIRTHDAY <b>62</b> YRS.	IF UNDER 1 YR. MONTHS DAYS HOURS MIN	IF UNDER 24 HRS. HOURS MIN	2c. DATE PRONOUNCED DEAD MONTH DAY YEAR <b>1-13-85</b>	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>S. Carolina</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Baltimore City</b>	
10. CITY OR TOWN OF DEATH <b>Baltimore</b>		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Rear 1212 Laurens Street</b>			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Handyman</b>		12b. KIND OF BUSINESS OR INDUSTRY
13a. STATE <b>Md.</b>		13b. COUNTY	13c. CITY OR TOWN <b>Balto.</b>	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	13e. STREET ADDRESS <b>00000</b>		
14. FATHER'S NAME FIRST MIDDLE LAST <b>Will Richardson</b>			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Mattie Wise</b>				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) <b>No</b>		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) <b>- -</b>		17. INFORMANT ADDRESS			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Hypertensive arteriosclerotic cardiovascular disease</b> <b>9043</b> XXXXXXXXXXXXXXXXXXXX Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) <b>disease</b> DUE TO, OR AS A CONSEQUENCE OF (c)							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a). <b>exposure</b>							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH <b>?</b> P.M. <b>1-?-85</b>		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>subject found lying on ground of vacant</b>					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) <b>rear vacant dwelling</b>					
21f. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2) <b>1212 Laurens Street Baltimore, Maryland</b>							
22a. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .							
ACTUAL SIGNATURE <b>Margarita A. Korell</b>		TITLE (SPECIFY). M.D. <b>Assistant</b> MEDICAL EXAMINER				DATE SIGNED <b>1-14-85</b>	
EXAMINER'S NAME (TYPE OR PRINT) <b>Margarita A. Korell, M.D.</b>		ADDRESS <b>111 Penn Street</b>					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Removal</b>		23b. DATE <b>1/17/85</b>		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN COUNTY STATE	
24. FUNERAL DIRECTOR NAME ADDRESS <b>Anatomy Board Balto., Md.</b>				25a. DATE REC'D. BY REGISTRAR <b>JAN 23 1985</b>		25b. REGISTRAR'S SIGNATURE <b>Davidson-Randall</b>	

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

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TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 24 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.



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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 4 should be detached for use on the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.  
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1- FOR STATE REGISTRAR **2146**

2-4 H. Address **2146**

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO. **85 01462**

1. DECEASED NAME (TYPE OR PRINT) <b>Rufus MM Richardson</b>			2. DATE OF DEATH MONTH DAY YEAR <b>1/18/85</b>			2b HOUR <b>130 P M</b>	
3. SEX <b>M</b>		4. RACE <b>Black</b>		5. DATE OF BIRTH <b>May 7 1928</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>56</b>	
7. BIRTHPLACE (STATE OR FOREIGN) <b>North Carolina</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Baltimore</b> MD.	
10. CITY OR TOWN OF DEATH <b>Baltimore</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION <b>Weyman Park Health Syst</b>				12a. USUAL OCCUPATION <b>Retired military</b>	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) <b>13b. STATE</b> <b>MD</b>		13b. COUNTY <b>A. A. Belvedere Park</b>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13. STREET ADDRESS, ZIP CODE <b>610 Belvedere Ave</b>	
14. FATHER'S NAME (TYPE OR PRINT) <b>Garfield</b>		15. MOTHER'S MAIDEN NAME <b>LILLIE MM Penny</b>		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> (IF YES, GIVE WAR OR DATES) <b>W/WW II Korea 24-38 7501</b>			
16b. SOCIAL SECURITY NO. <b>242-38 7501</b>		17. INFORMANT <b>LOURENA Y. Richardson</b>				ADDRESS <b>Same As 13E</b>	
18. CAUSE OF DEATH (Enter only one cause per line, for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a). <b>Respiratory failure</b> DUE TO, OR AS A CONSEQUENCE OF: (b). <b>Cachexia</b> DUE TO, OR AS A CONSEQUENCE OF: (c). <b>Pancreatic carcinoma with mets</b> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: a							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <b>1/18</b> 19 <b>85</b> , to <b>1/18</b> 19 <b>85</b> , that (I) (we) last saw the deceased alive on <b>1/18/85</b> 19 <b>85</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <b>D Holcombe</b>		DEGREE		ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		DATE SIGNED <b>1/18/85</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>David Holcombe</b>		22e. ADDRESS <b>Weyman Park Health System</b>					
23a. BURIAL, CREMATION, REMOVAL <b>Burial</b>		23b. DATE <b>1-23-85</b>		23c. NAME OF CEMETERY OR CREMATORY <b>MD Vets</b>		23d. LOCATION CITY OR TOWN COUNTY <b>Crownsville A.A. Md</b>	
24. FUNERAL DIRECTOR <b>Ann M. Hicks F.H.</b>		24b. ADDRESS <b>Forest Dr. Anna M. Hicks</b>		25a. DATE REC'D. BY REGISTRAR <b>JAN 24 1985</b>		25b. REGISTRAR'S SIGNATURE <b>John Davidson</b>	



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

## MEDICAL CERTIFICATION

FOR 1- STATE REGISTRAR										DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										REG. NO.									
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <b>HUMAN RICHMOND</b>										2a. DATE KNOWN OF DEATH ESTI. MATED <input checked="" type="checkbox"/> <b>1-11-85</b> MONTH DAY YEAR					2b. HOUR M <b>2:55P</b>														
3. SEX <b>Male</b>		4. RACE <b>White</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>9 19 27</b>		6. AGE (IN YEARS) (LAST BIRTHDAY) <b>57 YRS</b>		IF UNDER 1 YR. MONTHS DAYS HOURS MIN.		IF UNDER 24 HRS.		2c. DATE PRONOUNCED DEAD <b>1-11-85</b> MONTH DAY YEAR					2d. HOUR <b>2:55P</b>												
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Maryland</b>					7b. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>					8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>					9. <b>BALTIMORE CITY</b> OR COUNTY OF DEATH <b>Baltimore City</b> MD.														
10. CITY OR TOWN OF DEATH <b>Baltimore</b>					11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>3312 Keswick Road</b>										12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Mailroom</b>					12b. KIND OF BUSINESS OR INDUSTRY <b>Newspaper</b>									
13a. STATE <b>Md.</b>										13b. COUNTY					13c. CITY OR TOWN <b>Balto.</b>					13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>					13e. STREET ADDRESS <b>3312 Keswick Road 21211</b>				
14. FATHER'S NAME FIRST MIDDLE LAST <b>Samuel Richmond</b>										15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Pauline</b>																			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) <b>Unkn.</b>					16b. SOCIAL SECURITY NO. <b>216-24-0129</b>					17. INFORMANT ADDRESS <b>Charles Frommelt, 3312 Keswick Rd., Balto. Md. 21211</b>																			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Arteriosclerotic cardiovascular disease</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH																													
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).																													
19a. DATE OF OPERATION					19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?										20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>														
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH					21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>					21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)																			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>					21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)					21f. LOCATION STREET CITY OR TOWN COUNTY STATE																			
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: <b>Natural cause</b> <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> .																													
ACTUAL SIGNATURE <b>[Signature]</b>										TITLE (SPECIFY) M.D. <b>Assistant</b> MEDICAL EXAMINER										DATE SIGNED <b>1-12-85</b>									
EXAMINER'S NAME (TYPE OR PRINT) <b>Gregory R. Kauffman, M.D.</b>										ADDRESS <b>111 Penn Street</b>																			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Removal</b>					23b. DATE <b>1/17/85</b>					23c. NAME OF CEMETERY OR CREMATORY <b>Eastview Mem. Park</b>					23d. LOCATION CITY OR TOWN COUNTY STATE <b>Baltimore, Maryland</b>														
24. FUNERAL DIRECTOR NAME <b>George J. Gonce,</b> ADDRESS <b>4001 Ritchie Hwy. Balto., Md.</b>										25a. DATE REC'D. BY REGISTRAR <b>JAN 23 1985</b>					25b. REGISTRAR'S SIGNATURE <b>[Signature]</b>														



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be retained by the funeral director. Page 3 should be retained by the funeral director. Page 4 should be retained by the funeral director. Page 5 should be retained by the funeral director. Page 6 should be retained by the funeral director. Page 7 should be retained by the funeral director. Page 8 should be retained by the funeral director. Page 9 should be retained by the funeral director. Page 10 should be retained by the funeral director. Page 11 should be retained by the funeral director. Page 12 should be retained by the funeral director. Page 13 should be retained by the funeral director. Page 14 should be retained by the funeral director. Page 15 should be retained by the funeral director. Page 16 should be retained by the funeral director. Page 17 should be retained by the funeral director. Page 18 should be retained by the funeral director. Page 19 should be retained by the funeral director. Page 20 should be retained by the funeral director. Page 21 should be retained by the funeral director. Page 22 should be retained by the funeral director. Page 23 should be retained by the funeral director. Page 24 should be retained by the funeral director. Page 25 should be retained by the funeral director. Page 26 should be retained by the funeral director. Page 27 should be retained by the funeral director. Page 28 should be retained by the funeral director. Page 29 should be retained by the funeral director. Page 30 should be retained by the funeral director. Page 31 should be retained by the funeral director. Page 32 should be retained by the funeral director. Page 33 should be retained by the funeral director. Page 34 should be retained by the funeral director. Page 35 should be retained by the funeral director. 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Page 93 should be retained by the funeral director. Page 94 should be retained by the funeral director. Page 95 should be retained by the funeral director. Page 96 should be retained by the funeral director. Page 97 should be retained by the funeral director. Page 98 should be retained by the funeral director. Page 99 should be retained by the funeral director. Page 100 should be retained by the funeral director.

31- FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST MARY MARGARET RIDGWAY			2a. DATE OF DEATH MONTH DAY YEAR JANUARY 13 85		2b. HOUR 130A M
3. SEX FEMALE	4. RACE WHITE	5. DATE OF BIRTH MONTH DAY YEAR 05 19 10		6. AGE (IN YEARS LAST BIRTHDAY) 74 YRS.	IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.
7. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MARYLAND	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE CITY MD.		
10. CITY OR TOWN OF DEATH BALTIMORE	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) ST. AGNES HOSPITAL		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) HOMEMAKER		12b. KIND OF BUSINESS OR INDUSTRY ---
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)					
13a. STATE MARYLAND	13b. COUNTY BALTIMORE	13c. CITY OR TOWN LANSDOWNE	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13e. STREET ADDRESS / ZIP CODE 31 3rd AVENUE, 21227	
14. FATHER'S NAME FIRST MIDDLE LAST WILLIAM G. BROWN		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST CLARA R. SMITH			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO	16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 217-46-2775	17. INFORMANT ADDRESS JOHN W. RIDGWAY 1112 GLORIA AVENUE, 21227			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>End stage cong. heart failure / Pulm. edema</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>ischemic myocardial heart disease</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Renal failure</u>					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (this hospital) attended the deceased from <u>1/1</u> , 19 <u>85</u> , to <u>1/13</u> , 19 <u>85</u> , that (we) lost saw the deceased alive on <u>1/13</u> , 19 <u>85</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (b) (we) (did) (did not) view the body after death.					
22b. SIGNATURE <u>Amam</u>		DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>			22c. DATE SIGNED <u>1/13/85</u>
22d. PHYSICIAN'S NAME (TYPE OR PRINT) ARIL P. IMAM		22e. ADDRESS ST. AGNES HOSPITAL, 900 S. CATON AVENUE			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL	23b. DATE 01-16-85	23c. NAME OF CEMETERY OR CREMATORY MEADOWRIDGE MEM. PK.	23d. LOCATION CITY OR TOWN COUNTY STATE ELKRIDGE HOWARD MARYLAND		
24. FUNERAL DIRECTOR NAME HUBBARD FUNERAL HOME, INC. 4107 WILKENS AVE.		24a. DATE REC'D. BY REGISTRAR JAN 14 1985	24b. REGISTRAR'S SIGNATURE <u>John W. Ridgway</u>		

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STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

FOR  
1- STATE  
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) <b>ROBERT RIFKIN</b>			2a. DATE KNOWN OF DEATH MATED <input checked="" type="checkbox"/> 1-14-85 19		2b. HOUR <b>9:26A</b>
3. SEX <b>M</b>	4. RACE <b>W</b>	5. DATE OF BIRTH MONTH DAY YEAR <b>Oct 15/18</b>	6. AGE (IN YEARS LAST BIRTHDAY) <b>66 YRS.</b>	IF UNDER 1 YR. MONTHS DAYS HOURS MIN.	IF UNDER 24 HRS.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Balto</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U S A</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
10. CITY OR TOWN OF DEATH <b>Baltimore</b>		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION <b>841 E. Lombard Street</b>		12a. USUAL OCCUPATION (TYPE OF WORK OR MOST OF WORKING LIFE) <b>Merchant</b>	
13a. STATE <b>Md.</b>		13b. COUNTY <b>Balto</b>		13c. CITY OR TOWN <b>Balto</b>	
14. FATHER'S NAME FIRST <b>Harper</b> MIDDLE <b>Rifkin</b> LAST <b>Rifkin</b>		15. MOTHER'S MAIDEN NAME FIRST <b>Boree</b> MIDDLE <b>Latito</b> LAST <b>Latito</b>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) <b>11</b>		16b. SOCIAL SECURITY NO. <b>2181011657</b>		17. INFORMANT ADDRESS <b>841 E Lombard St</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Arteriosclerotic cardiovascular disease</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?			20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. <b>19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that I took charge of the remains described above, held on death resulted from: <b>Natural causes</b> <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> . Autopsy <input type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion					
ACTUAL SIGNATURE <b>Margarita A. Korell</b>		TITLE (SPECIFY) <b>Assistant</b>		DATE SIGNED <b>1-16-85</b>	
EXAMINER'S NAME (TYPE OR PRINT) <b>Margarita A. Korell, M.D.</b>		ADDRESS <b>111 Penn Street</b>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>1/17/85</b>		23c. NAME OF CEMETERY OR CREMATORY <b>St. Luke's</b>	
24. FUNERAL DIRECTOR NAME <b>Debra</b> ADDRESS <b>132 E. North</b>		25a. DATE REC'D. BY REGISTRAR <b>JAN 18 1985</b>		25b. REGISTRAR'S SIGNATURE <b>[Signature]</b>	

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

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(VR A15 ME (5))



DMO

WATER



NOTICE

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STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. FOR STATE REGISTRAR		2a. DATE OF DEATH MONTH DAY YEAR		2b. HOUR	
1. DECEASED NAME (TYPE OR PRINT)		FIRST MIDDLE LAST		JANUARY 16, 1985	
LISA JANE RINE				07:35AM	
3. SEX		4. RACE		5. DATE OF BIRTH MONTH DAY YEAR	
Female		White		Nov 30, 1962	
6. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		6. AGE (IN YEARS LAST BIRTHDAY)	
Washington, DC		USA		22 YRS.	
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		9. BALTIMORE CITY OR COUNTY OF DEATH	
BALTIMORE		THE JOHNS HOPKINS HOSPITAL		BALTIMORE CITY MD.	
12a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)		12b. KIND OF BUSINESS OR INDUSTRY		12c. KIND OF BUSINESS OR INDUSTRY	
13a. STATE		13b. CITY OR TOWN		13c. STREET ADDRESS / ZIP CODE	
Maryland		Montgomery Chevy Chase		8800 Altimont Lane 20815	
14. FATHER'S NAME FIRST MIDDLE LAST		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST		16. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)	
Alford J. Rine		Audrey Jane Baaf		no	
16b. SOCIAL SECURITY NO.		17. INEORMANT ADDRESS		17. INEORMANT ADDRESS	
578-98-1517		Audrey Jane Rine/737 Shore Rd.		Somers Point, NJ	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART I. DEATH WAS CAUSED BY:					5 minutes
IMMEDIATE CAUSE (a) CARDIAC ARREST					
DUE TO, OR AS A CONSEQUENCE OF					2 days
(b) Severe Metabolic abnormalities					
DUE TO, OR AS A CONSEQUENCE OF					2 days
(c) BRAIN DEATH					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)					
Leukemia					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?	
				YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)	
		P.M. 19			
21d. INJURY OCCURRED		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION CITY OR TOWN COUNTY STATE	
WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK					
22a. I certify that (I) (this hospital) attended the deceased from 12/29/84 to 1/16/85, that (I) (we) last saw the deceased alive on 1/16/85, and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE		DEGREE		22c. DATE SIGNED	
Paul Katzenstein		MD		1/16/85	
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS			
PAUL KATZENSTEIN		Johns Hopkins Hospital			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY	
Cremation		1-17-85		Lee's Crematory	
23d. LOCATION CITY OR TOWN		23e. LOCATION COUNTY		23f. LOCATION STATE	
Washington		Washington		D.C.	
24. FUNERAL DIRECTOR NAME		24b. DATE REC'D. BY REGISTRAR		24c. REGISTRAR'S SIGNATURE	
Marshall's Funeral Home		JAN 21 1985		Julia Davidson-Randall	
4217 9th St NW: Washington, D.C.					

MEDICAL CERTIFICATION

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified and a medical examiner's certificate must be filed in the death record.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician or administrator, it should be detached for use on the burial-transit permit. Then please remove all papers, tags, and labels from the death certificate and return them to the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be signed by the attending physician or administrator, and that the death certificate be filed in the death record.

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STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

FOR  
STATE  
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) <b>BABY GIRL (SARA) RINGROSE</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>1-10-85</b>		2b. HOUR <b>12:14 P.M.</b>		
3. SEX <b>FEMALE</b>		4. RACE <b>WHITE</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>1-7-85</b>		6. AGE (IN YEARS LAST BIRTHDAY) MONTHS DAYS HOURS MIN. <b>3</b>	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>MARYLAND</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>BALTIMORE CITY</b> MD.	
10. CITY OR TOWN OF DEATH <b>BALTIMORE</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>SAINT AGNES HOSPITAL</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>INFANT</b>		12b. KIND OF BUSINESS OR INDUSTRY	
13a. STATE <b>MARYLAND</b>		13b. COUNTY <b>BALTIMORE</b>		13c. CITY OR TOWN <b>BALTIMORE</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
13e. STREET ADDRESS <b>1631 INVIERNESS AVENUE</b>		13f. CITY LIMITS <b>21230</b>		13g. STREET ADDRESS <b>1631 INVIERNESS AVENUE</b>		13h. CITY LIMITS <b>21230</b>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>ALBERT RINGROSE</b>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>JULIANNA BURG</b>		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>N/A</b>		16b. SOCIAL SECURITY NO. <b>N/A</b>	
16c. ADDRESS <b>BENSON M. SILVERMAN</b>		16d. ADDRESS <b>ST. AGNES HOSP.</b>		17. INFORMANT <b>BENSON M. SILVERMAN</b>		17. ADDRESS <b>ST. AGNES HOSP.</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>MASSIVE INTRACRANIAL HEMORRHAGE</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>SEVERE IMMATURITY</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>SEVERE HYALINE MEMBRANE DISEASE</b>							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>24 HRS.</b>
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <b>SEVERE HYALINE MEMBRANE DISEASE</b>							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <b>1-7</b> , 19 <b>85</b> , to <b>1-10</b> , 19 <b>85</b> , that (I) (we) lost saw the deceased alive on <b>1-10</b> , 19 <b>85</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <b>Benson M. Silverman M.D.</b>		DEGREE		22c. DATE SIGNED <b>1/10/85</b>		22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>BENSON M. SILVERMAN M.D.</b>	
22e. ADDRESS <b>900 CATON AVENUE BALTO. MD. 21229</b>		22f. ADDRESS		22g. ADDRESS		22h. ADDRESS	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>1/14/85</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Meadowridge Mem Pk. Dorsey Howard Md.</b>		23d. LOCATION CITY OR TOWN COUNTY STATE	
24. FUNERAL DIRECTOR NAME <b>Ambrose, Inc. 1328 Sulphur Spring Rd.</b>		24b. ADDRESS <b>1328 Sulphur Spring Rd.</b>		25a. DATE REC'D. BY REGISTRAR <b>JAN 17 1985</b>		25b. REGISTRAR'S SIGNATURE <b>Julia Davidson-Randall</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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DANIEL W. J. J. J. J.

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STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 5 0 1 4 6 8

FOR  
1 - STATE  
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) <i>Bessie Roberts</i>			2a. DATE OF DEATH MONTH DAY YEAR <i>1 27 85</i>		2b. HOUR <i>5 AM</i>
3. SEX <i>FEMALE</i>	4. RACE <i>Black</i>	5. DATE OF BIRTH MONTH DAY YEAR <i>12 25 95</i>	6. AGE (IN YEARS LAST BIRTHDAY) <i>✓ 88</i> YRS.	IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (COUNTRY) <i>N. CAROLINA</i>	7b. CITIZEN OF WHAT COUNTRY? <i>USA</i>	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH <i>Balto. City</i> MD.		
10. CITY OR TOWN OF DEATH <i>Baltimore</i>	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NONE, SUCH AS CARE, GIVE STREET ADDRESS) <i>Lutheran Hospital</i>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <i>Domestic</i>		12b. KIND OF BUSINESS OR INDUSTRY
13a. STATE <i>Md.</i>			13b. COUNTY	13c. CITY OR TOWN <i>Balto.</i>	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
14. FATHER'S NAME FIRST MIDDLE LAST <i>Jim Jordan</i>			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <i>Rebecca</i>		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <i>No</i>		16b. SOCIAL SECURITY NO. <i>218-01-9626</i>		17. INFORMANT ADDRESS	

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)  
PART I. DEATH WAS CAUSED BY:

APPROXIMATE INTERVAL  
BETWEEN ONSET AND DEATHIMMEDIATE CAUSE (a) *Sepsis*

DUE TO, OR AS A CONSEQUENCE OF

Conditions, if any, which  
gave rise to immediate  
cause (a), stating the  
underlying cause last.

(b)

DUE TO, OR AS A CONSEQUENCE OF

(c)

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)

MEDICAL CERTIFICATION

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHITE <input type="checkbox"/> NOT WHITE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (if (this hospital) attended the deceased from <i>02-04</i> 19 <i>84</i> to <i>01-27</i> 19 <i>85</i> , that (we) last saw the deceased alive on <i>01-27</i> 19 <i>85</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.			
22b. SIGNATURE <i>Sissay Awolika</i>	DEGREE	ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>	22c. DATE SIGNED <i>1/27/85</i>
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <i>SISSAY AWOLIKA</i>		22e. ADDRESS <i>Lutheran Hospital</i>	

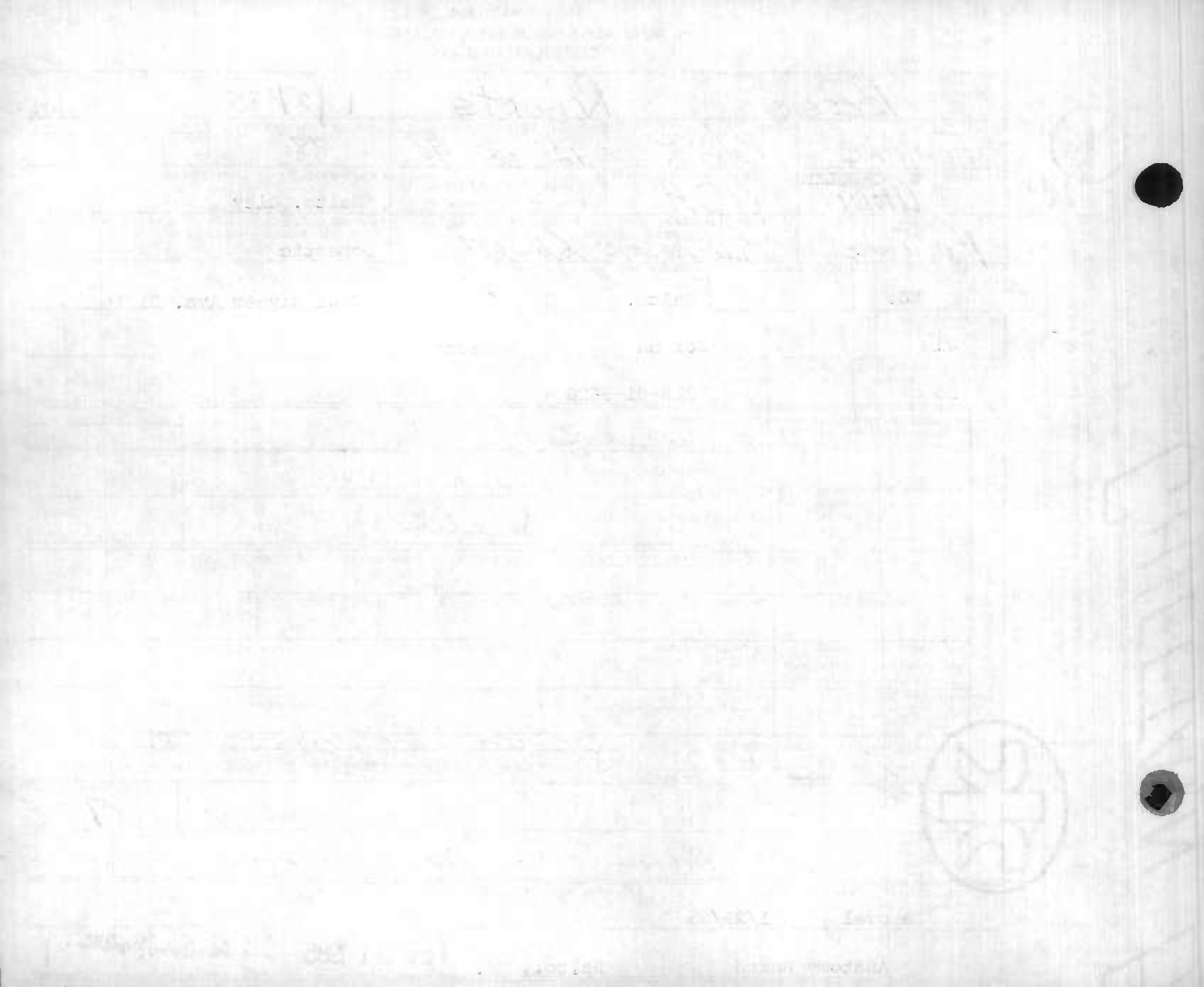
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>Removal</i>	23b. DATE <i>1/29/85</i>	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION CITY OR TOWN COUNTY STATE <i>Balto., Md.</i>
24. FUNERAL DIRECTOR NAME <i>Anatomy Board</i>		25a. DATE REC'D. BY REGISTRAR <i>FEB 01 1985</i>	
ADDRESS <i>Balto., Md.</i>		25b. REGISTRAR'S SIGNATURE <i>John Davidson-Randall</i>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Possession of this certificate is retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.





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TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

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(VR A15 ME (5))

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

1- FOR STATE REGISTRAR										85 01469																																							
1 DECEASED NAME (TYPE OR PRINT)										2a. DATE KNOWN OF ESTI. DEATH MATED										2b. HOUR																													
Lyle G. Roberts, Sr.										1/ 3/ 19 85										8:15 A M																													
3. SEX			4. RACE			5. DATE OF BIRTH MONTH DAY YEAR			6. AGE (IN YEARS LAST BIRTHDAY)			7. IF UNDER 1 YR. MONTHS DAYS HOURS MIN.			7c. DATE PRONOUNCED DEAD			8. HOUR																															
male			black			10/24/ 12			72 YRS.						1/3/ 19 85			A M																															
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)										7b. CITIZEN OF WHAT COUNTRY?										8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>										9. BALTIMORE CITY OR COUNTY OF DEATH																			
Washington, Va.										U.S.										Baltimore City, MD																													
10. CITY OR TOWN OF DEATH										11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)										12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)										12b. KIND OF BUSINESS OR INDUSTRY																			
Baltimore										2506 Madison Ave.																																							
13a. STATE										13b. COUNTY										13c. CITY OR TOWN										13d. INSIDE CITY LIMITS?										13e. STREET ADDRESS									
Md.																				Balto.										YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>										2506 Madison Ave. 21217									
14. FATHER'S NAME FIRST MIDDLE LAST										15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST																																							
James E. Roberts										Lavinia E. King																																							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)										16b. SOCIAL SECURITY NO.										17. INFORMANT										ADDRESS																			
no										212-01-1995-A										Lyle G. Roberts, Jr.										5585 Kennison Ave.																			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY:										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH																																							
IMMEDIATE CAUSE (a) Arteriosclerotic Hypertensive Cardiovascular Disease																																																	
DUE TO, OR AS A CONSEQUENCE OF																																																	
Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.																																																	
(b)																																																	
DUE TO, OR AS A CONSEQUENCE OF																																																	
(c)																																																	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a):																																																	
Chronic Obstructive Pulmonary Disease, Chronic Alcoholism																																																	
19a. DATE OF OPERATION										19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?										20. AUTOPSY?																													
																				YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>																													
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH										21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19										21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)																													
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>										21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)										21f. LOCATION STREET CITY OR TOWN COUNTY STATE																													
22a. I certify that I took charge of the remains described above, held on										Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion																																							
death resulted from:										Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>																																							
ACTUAL SIGNATURE										TITLE (SPECIFY)										DATE SIGNED																													
										M.D. Assistant MEDICAL EXAMINER										1/3/85																													
EXAMINER'S NAME (TYPE OR PRINT)										ADDRESS																																							
Gregory R. Kauffman, M.D.										111 Penn St.																																							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)										23b. DATE										23c. NAME OF CEMETERY OR CREMATORY										23d. LOCATION CITY OR TOWN COUNTY STATE																			
Burial										1/ 7 /85										St. Thomas Cem.										Randallstown, Md.																			
24. FUNERAL DIRECTOR NAME										ADDRESS										25a. DATE REC'D. BY REGISTRAR										REGISTRAR'S SIGNATURE																			
Leroy O. Dyett										4600 Liberty Hgts. Ave.										JAN 4 1985										Chia Davidson-Randall																			

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DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. FOR  
STATE  
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) <b>Gladys Mae Robinson</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>1/23/85</b>		2b. HOUR M <b></b>
3. SEX <b>Female</b>	4. RACE <b>Black</b>	5. DATE OF BIRTH MONTH DAY YEAR <b>1/17/14</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>70</b> YRS. MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>N.C.</b>	7b. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Balto. City</b> MD.	
10. CITY OR TOWN OF DEATH <b>Balto.</b>	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>1831 Druid Hill Ave.</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE <b>Md.</b>			13b. COUNTY <b></b>	13c. CITY OR TOWN <b>Balto.</b>	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
14. FATHER'S NAME FIRST MIDDLE LAST <b>Willie Freeman</b>			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Elizabeth Spruil</b>		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) <b>no</b>		16b. SOCIAL SECURITY NO. <b>217-22-8605</b>		17. INFORMANT ADDRESS <b>Mary O'Neal 1831 Druid Hill Ave.</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cardio Pulmonary arrest</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>Acute Dehydration</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>Diabetic Melitus</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from <b>1/17/85</b> to <b>1/23/85</b> , that (I) (we) last saw the deceased alive on <b>1/17/85</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE <b>[Signature]</b>		DEGREE <b>MD</b>		22c. DATE SIGNED <b>1/24/85</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>R. W. V. A. M. S.</b>		22e. ADDRESS <b>4605 EDMONDSON AVE</b>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>1/20/85</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Mt. Auburn</b>		23d. LOCATION CITY TOWN COUNTY STATE <b>Balto. Md.</b>
24. FUNERAL DIRECTOR NAME <b>C. Wainwright</b>		ADDRESS <b>2700 Edmondson Ave.</b>		25a. DATE REC'D. BY REGISTRAR <b>JAN 25 1985</b>	
25b. REGISTRAR'S SIGNATURE <b>[Signature]</b>					

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

2012 COTTON 10103 2102

WV 10103 2102



1-  
FOR  
STATE  
REGISTRAR

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) <b>KEVIN DORSEY ROBINSON</b>			2a. DATE KNOWN OF DEATH ESTIMATED <input checked="" type="checkbox"/> MONTH DAY YEAR <b>1-28-85</b>			2b. HOUR M <b>8:22A</b>		
3. SEX <b>Male</b>	4. RACE <b>Black</b>	5. DATE OF BIRTH MONTH DAY YEAR <b>12 14 84</b>	6. AGE (IN YEARS) LAST BIRTHDAY YRS. MONTHS DAYS <b>1 20</b>	IF UNDER 1 YR. HOURS MIN. <b>20</b>		7c. DATE PRONOUNCED DEAD MONTH DAY YEAR <b>1-28-85</b>		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>MD</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Baltimore City</b>		
10. CITY OR TOWN OF DEATH <b>Baltimore</b>		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Sinai Hospital</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY
13a. STATE <b>MD</b>		13b. COUNTY <b>Baltimore</b>		13c. CITY OR TOWN <b>Baltimore</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
14. FATHER'S NAME FIRST MIDDLE LAST <b>Kevin D. Robinson Sr.</b>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Dorothy Terry</b>		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) (IF YES, GIVE WAR OR DATES) <b>No</b>				
16b. SOCIAL SECURITY NO. <b>N/A</b>		17. INFORMANT ADDRESS <b>Ethel M. Terry 4406 Fernhill Ave.</b>						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Pneumonia</b> <b>Sudden infant death syndrome</b> DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2 (OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I)								
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?					20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)				
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE				
22a. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: <u>Natural causes</u> <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>								
ACTUAL SIGNATURE <i>Margarita A. Korell</i>		TITLE (SPECIFY) <b>Assistant</b>		MEDICAL EXAMINER			DATE SIGNED <b>1-28-85</b>	
EXAMINER'S NAME (TYPE OR PRINT) <b>Margarita A. Korell, M.D.</b>		ADDRESS <b>111 Penn Street</b>						
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>2/1/85</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Cedar Hill Cem.</b>			23d. LOCATION CITY OR TOWN COUNTY STATE <b>Anne Arundel Co. MD</b>	
24. FUNERAL DIRECTOR NAME <b>Wm. C. March F/H</b>				25a. DATE REC'D. BY REGISTRAR <b>1-30-1985</b>		25b. REGISTRAR'S SIGNATURE <i>Davidson-Randall</i>		

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 24 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD, 21201

20% COTTON FIBER



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

07/84  
25MDHMH - 17  
(VR A15 ME (5))

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										REG. NO.			
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST ROSCOE Warren ROBINSON										2a. DATE KNOWN OF DEATH ESTIMATED MONTH DAY YEAR 1 17 19 85		2b. HOUR M 2:45 P.M.	
3. SEX male		4. RACE black		5. DATE OF BIRTH MONTH DAY YEAR 6 23 39		6. AGE (IN YEARS) (LAST BIRTHDAY) 45 YRS.		7. IF UNDER 1 YR. MONTHS DAYS HOURS MIN.		7c. DATE PRONOUNCED DEAD MONTH DAY YEAR 1 17 19 85			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) N. Carolina			7b. CITIZEN OF WHAT COUNTRY? U.S.A.			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD				
10. CITY OR TOWN OF DEATH Baltimore			11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Maryland General Hospital					12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY			
USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)													
13a. STATE Maryland			13b. COUNTY		13c. CITY OR TOWN Baltimore		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 1713 Guilford Ave 21202				
14. FATHER'S NAME FIRST MIDDLE LAST Roscoe Robinson					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Otella Bethune								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) NO					16b. SOCIAL SECURITY NO. N/A		17. INFORMANT ADDRESS Alberta McEachin 3213 Presstman St.						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>fatty metamorphosis of the liver complicated by pneumonia</u> <del>HEART DISEASE</del> Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last: (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH													
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I a.													
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?						20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .													
ACTUAL SIGNATURE <u>Ann M. Dixon</u>				TITLE (SPECIFY) M.D. Assistant				DATE SIGNED 1-18-85					
EXAMINER'S NAME (TYPE OR PRINT) Ann M. Dixon, M.D.				ADDRESS 111 Penn St., Balto., Md. 21201									
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL			23b. DATE 1/21/85		23c. NAME OF CEMETERY OR CREMATORY Sandy Grove Cemetery			23d. LOCATION CITY OR TOWN COUNTY STATE Fayetteville, N.C.					
24. FUNERAL DIRECTOR NAME ADDRESS Wm C March F/H Inc . 1101 E North Ave.						25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE JAN 21 1985					

MEDICAL CERTIFICATION

20% COLONY LIGHT

DMO

1/4 N 1/2



100% COTTON

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

85 01473

FOR  
1- STATE  
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST William ROCK			2a. DATE OF DEATH MONTH DAY YEAR JAN. 9 1985		2b. HOUR 11:50 PM
3. SEX MALE	4. RACE CAUCASIAN	5. DATE OF BIRTH MONTH DAY YEAR MARCH 10 1904		6. AGE (IN YEARS LAST BIRTHDAY) 80 YRS	IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) NEW YORK	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE CITY MD.	
10. CITY OR TOWN OF DEATH BALTIMORE	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) LEVINGAUS HEBREW GERIATRIC CENTER - HOSPITAL			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)	
13a. STATE MARYLAND			13b. COUNTY	13c. CITY OR TOWN BALTIMORE	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
14. FATHER'S NAME FIRST MIDDLE LAST MEYER ROCK			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST RACHZEL TABACHNICK		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 650-05-5264		17. INFORMANT ADDRESS Michael ROCK	

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)  
PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) METASTATIC CA

DUE TO, OR AS A CONSEQUENCE OF

Conditions, if any, which  
gave rise to immediate  
cause (a), stating the  
underlying cause last.(b)  
DUE TO, OR AS A CONSEQUENCE OF

(c)

APPROXIMATE INTERVAL  
BETWEEN ONSET AND DEATH

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (c)

## MEDICAL CERTIFICATION

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (this hospital) attended the deceased from 12/13, 19 84, to 1/9, 19 85, that (we) lost saw the deceased alive on 1/9, 19 85, and that in (our) opinion death occurred on the date and hour and from the causes stated above, (we) (did) (not) view the body after death.			
22b. SIGNATURE Esterlita O. Kw	DEGREE M.D. ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>	22c. DATE SIGNED 1/9/85	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) ESTRELITA O. KW		22e. ADDRESS LEVINGAUS HEBREW GERIATRIC CENTER - HOSPITAL	

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Removal	23b. DATE 1-9-85	23c. NAME OF CEMETERY OR CREMATORY HEBREW MEMORIAL F.H.	23d. LOCATION CITY OR TOWN COUNTY STATE BALT. ISRAEL
24. FUNERAL DIRECTOR NAME Hebrew Memorial F.H.		ADDRESS 1100 Reisterstown Rd	25a. DATE REC'D BY REGISTRAR JAN 9 1985
			25b. REGISTRAR'S SIGNATURE Julia Gordon-Rosier

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.



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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filled within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

DHMH - 16 50M 4/82  
(VRA 15, 4)

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. FOR  
STATE  
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT)		FIRST	MIDDLE	LAST	2a. DATE OF DEATH	MONTH	DAY	YEAR	2b. HOUR
MAGGIE NORA RODGERS					1	8	85		M
3. SEX	4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YEAR		IF UNDER 24 HRS
FEMALE	BLACK		MONTH DAY YEAR 10 11 1897		87 YRS		MONTHS DAYS HOURS MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH				
NORTH CAR.	USA				BALTIMORE MD.				
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY		
BALTO.		3707 COLBORNE RD.							
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)		13b. COUNTY		13c. CITY OR TOWN	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>				
MD.				BALTO.	13e. STREET ADDRESS 3707 COLBORNE RD. 21229				
14. FATHER'S NAME FIRST MIDDLE LAST		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST							
GEORGE		WYNN		MOLLIE MAE LAZIE					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS					
NO		243-16-4256		BEULAH BANKS 3707 COLBORNE RD.					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiopulmonary arrest</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Congestive heart failure</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: } DUE TO, OR AS A CONSEQUENCE OF (c) <u>Hypertensive cardiomyopathy</u> PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: a <u>① Ovarian neoplasm ② Alzheimer's disease</u>									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>Immediate</u> <u>5 years</u> <u>5 years</u>
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOT BY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (1) (this hospital) attended the deceased from <u>March</u> 19 <u>83</u> , to <u>January 9</u> 19 <u>85</u> , that (1) (we) lost saw the deceased alive <u>December 12</u> 19 <u>84</u> , and that in (my) (aur) opinion death occurred on the date and hour and from the causes stated above. (1) (we) (did) (did not) view the body after death.		22b. SIGNATURE <u>Scott Kaufmann</u> 22d. PHYSICIAN'S NAME (TYPE OR PRINT) <u>Scott Kaufmann</u>			DEGREE <u>M.D.</u> 22e. ADDRESS <u>600 N. Wolfe Street. Baltimore 21205</u>		22c. DATE SIGNED <u>1/10/85</u>		
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (CITY OR TOWN COUNTY STATE)			
BURIAL		1/ /85		ARBUS MEM. PK.		BALTO. MD. <u>Pondale</u>			
24. FUNERAL DIRECTOR NAME ADDRESS		25a. DATE RECD BY REGISTRAR		25b. REGISTRAR'S SIGNATURE					
LEROY O. DYETT 4600 LIBERTY HGTS AVE.									

MEDICAL CERTIFICATION

92

BP





STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1 - FOR  
STATE  
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <b>VICTOR RODMAN</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>1- 19-85</b>		2b. HOUR <b>11:50 A.M.</b>				
3. SEX <b>Male</b>		4. RACE <b>White</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>6 27 17</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>67</b>		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Maryland</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Baltimore City</b> MD.			
10. CITY OR TOWN OF DEATH <b>Balto.</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Francis Scott Key Med. Ctr.</b>			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Crane Operator</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Beth. Steel</b>		
13a. STATE <b>Maryland</b>		13b. COUNTY <b>Balto.</b>		13c. CITY OR TOWN <b>Dundalk</b>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE <b>15 Centre Ave. 21222</b>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>Joseph Rodman</b>				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Ida Narutowicz</b>					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO. <b>213-07-9124</b>		17. INFORMANT <b>Rose T. Rodman</b>		ADDRESS <b>Same as 13e</b>			

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)  
PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a)

**CARDIO PULMONARY ARREST**APPROXIMATE INTERVAL  
BETWEEN ONSET AND DEATH

Conditions, if any, which  
gave rise to immediate  
cause (a), stating the  
underlying cause last.

DUE TO, OR AS A CONSEQUENCE OF

(b)

**CORONARY ARTERY DISEASE**

DUE TO, OR AS A CONSEQUENCE OF

(c)

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: **CO-PD.**

MEDICAL CERTIFICATION

19a. DATE OF OPERATION <b>me</b>		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>me</b>		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. <b>me 19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) <b>me</b>			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) <b>me</b>		21f. LOCATION STREET CITY OR TOWN COUNTY STATE <b>me</b>			
22a. I certify that (I) (this hospital) attended the deceased from <b>4-13-84</b> to <b>1-19-85</b> , that (I) (we) lost saw the deceased alive on <b>1-17-85</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <b>Singer A. J. J.</b>				DEGREE		22c. DATE SIGNED <b>1/22/85</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>SUR J. J. J.</b>				22e. ADDRESS <b>JULKA MD 2900 Dunbar Road Baltimore</b>			

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>1-23-85</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Sacred Ht of Jesus</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Balto., Maryland</b>	
24. FUNERAL DIRECTOR NAME ADDRESS <b>Duda-Ruck inc. 7922 Wise Ave. Balto. Md. 21222</b>				25a. DATE REC'D. BY REGISTRAR <b>JAN 23 1985</b>		25b. REGISTRAR'S SIGNATURE <b>[Signature]</b>	





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed with the health officer after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH									
1. DECEASED NAME (TYPE OR PRINT) <b>OTTO DIEDRICH ROHLFS, Jr.</b>						7a. DATE OF DEATH MONTH DAY YEAR <b>1-10-85</b>		7b. HOUR M <b>1900</b>	
3. SEX <b>MALE</b>		4. RACE <b>WHITE</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>9-3-1913</b>		6. AGE (IN YEARS LAST BIRTHDAY) YRS <b>71</b>		8. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN. <b>71</b>	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Seattle Wash.</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Baltimore</b> MD.			
10. CITY OR TOWN OF DEATH <b>Balt. Md.</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Shock Trauma U.M.V.</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Mining Engineer</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Retired</b>	
13a. STATE <b>Md.</b>		13b. COUNTY <b>N</b>		13c. CITY OR TOWN <b>Baltimore</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE <b>3811 Canterbury Rd. 21218</b>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>OTTO D. ROHLFS</b>				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Catherine McMillan McMillan</b>					
16a. WAS DECEASED EVER IN ARMED SERVICES? (YES, NO OR UNKNOWN) <b>Yes</b>				16b. SOCIAL SECURITY NO. <b>531-12-3012</b>		17. INFORMANT'S NAME AND ADDRESS <b>Mrs. Madeline J. Rohlf 3811 Canterbury Rd. Apt. 804-21218</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>GUN SHOT WOUND TO HEAD</b> DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: _____									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: a <b>Metastatic carcinoma of lung</b>									
19a. DATE OF OPERATION <b>NONE</b>		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR MONTH DAY YEAR <b>3:00 PM 1-10-85</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) <b>Self-inflicted.</b>					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input checked="" type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) <b>home</b>		21f. LOCATION STREET CITY OR TOWN COUNTY STATE <b>3811 Canterbury Rd., Balto. Md.</b>					
22a. I certify that (I) (this hospital) attended the deceased from <b>1/10/85</b> to <b>1/10/85</b> that (I) (we) last saw the deceased alive on <b>1/10/85</b> , and that in (my) (our) opinion death occurred on the same and from the causes stated above. (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <b>Rex A. Henderson</b>				DEGREE <b>MD</b>		22c. DATE SIGNED <b>JAN 14 1985</b>		22d. ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>	
22e. PHYSICIAN'S NAME (TYPE OR PRINT) <b>Rex A. Henderson</b>				22f. ADDRESS <b>MEMSS</b>					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Cremation</b>		23b. DATE <b>Jan. 14, 1985</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Green Mount Crematorium</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Baltimore City, Md.-21202</b>			
24. FUNERAL DIRECTOR NAME ADDRESS <b>Henry Sander &amp; Sons, Inc., Balto., Md. 21213</b>				25a. DATE REC'D. BY REGISTRAR <b>JAN 14 1985</b>		25b. REGISTRAR'S SIGNATURE <b>[Signature]</b>			

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STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1- FOR  
STATE  
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) <i>Bernard Vincent Ronuckeo</i>			2a. DATE OF DEATH MONTH DAY YEAR <i>Jan. 14 '85</i>			2b. HOUR <i>10:01 P</i>	
3. SEX <i>Male</i>		4. RACE <i>White</i>		5. DATE OF BIRTH MONTH DAY YEAR <i>12 27 23</i>		6. AGE (IN YEARS LAST BIRTHDAY) <i>61</i> YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN) <i>Maryland</i>		7b. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <i>Baltimore City</i> MD.	
10. CITY OR TOWN OF DEATH <i>Baltimore</i>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <i>Francis Scott Key Medical Center</i>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <i>Retired</i>	
12b. KIND OF BUSINESS OR INDUSTRY <i>U.S. Gov't.</i>		13. STREET ADDRESS / ZIP CODE <i>7136 Eastbrook Ave. 21224</i>					
14. FATHER'S NAME FIRST MIDDLE LAST <i>Raphael Ronocchia-Ronuckeo</i>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <i>Grace Maggio</i>		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <i>Yes</i> IF <i>W.W. 2</i> WAR DATES			
16b. SOCIAL SECURITY NO. <i>217-16-8030</i>		17. INFORMANT ADDRESS <i>Loretta E. Ronuckeo 7136 Eastbrook Ave.</i>					

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>massive lateral myocardial infarction</i>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
DUE TO, OR AS A CONSEQUENCE OF (b) <i>atherosclerotic cardiovascular disease</i>			
DUE TO, OR AS A CONSEQUENCE OF (c)			

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 11a:

19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <i>P.M. 19</i>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <i>Jan 14</i> , 19 <i>85</i> , to <i>Jan 14</i> , 19 <i>85</i> , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on <i>Jan 14</i> , 19 <i>85</i> , and that in <input checked="" type="checkbox"/> (our) opinion death occurred on the date and hour and from the causes stated above, <input checked="" type="checkbox"/> (we) [did] <input type="checkbox"/> (we) did not view the body after death.							
22b. SIGNATURE <i>Catherine Chow</i>		DEGREE <i>MD</i>		ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED <i>1/14/85</i>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <i>Catherine Chow</i>		22e. ADDRESS <i>FSKMC, 4940 Eastern Ave., Balto., Md.</i>					

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>Burial</i>		23b. DATE <i>1-18-85</i>		23c. NAME OF CEMETERY OR CREMATORY <i>Holly Hills Mem. Garden</i>		23d. LOCATION CITY OR TOWN COUNTY STATE <i>Middle River Balto. Co., Md.</i>	
24. FUNERAL DIRECTOR NAME <i>Charles S. Zeiler &amp; Son Inc.</i>				ADDRESS <i>6224 Eastern Ave.</i>		25a. DATE REC'D. BY REGISTRAR <i>JAN 16 1985</i>	
						25b. REGISTRAR'S SIGNATURE <i>Davidson-Rodell</i>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with 48 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified and a post-mortem examination required.

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Charles L. Zeller & Son Inc. 624 Water St. No.

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT)		2a. DATE OF DEATH		2b. HOUR	
John H. ROPER		January 23, 1985		M	
3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE	7. BALTIMORE CITY OR COUNTY OF DEATH	
Male	White	January 7, 1945	40	Baltimore County City MD	
7a. BIRTHPLACE	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED	9. BALTIMORE CITY OR COUNTY OF DEATH		
Virginia	USA	NEVER MARRIED	Baltimore County City MD		
10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION	12a. USUAL OCCUPATION			
Baltimore	4527 Arabia	B.&O. Freight Conductor			
13a. STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET ADDRESS / ZIP CODE	
Md.		Baltimore	YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	4527 Arabia Ave. 21214	
14. FATHER'S NAME	15. MOTHER'S MAIDEN NAME	16a. WAS DECEASED EVER IN U.S. ARMED FORCES?			
John Roper	Claudine Bush	yes <input checked="" type="checkbox"/> NO OR UNKNOWN <input type="checkbox"/> Vietnam			
16b. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS			
216-44-0536	Mrs. Jane B. Roper	Same			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 1. DEATH WAS CAUSED BY:					
IMMEDIATE CAUSE (a) Cause undetermine					
DUE TO, OR AS A CONSEQUENCE OF					
(b) Dysrhythmia					
DUE TO, OR AS A CONSEQUENCE OF					
(c)					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)					
19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY?	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?		
		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
	HOUR A.M. MONTH DAY YEAR				
	P.M. 19				
21d. INJURY OCCURRED	21e. PLACE OF INJURY	21f. LOCATION			
WHITE <input type="checkbox"/> NOT WHITE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		CITY OR TOWN COUNTY STATE			
22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from November 19, 84, to Present time, that (I) (we) last saw the deceased alive on 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. <input checked="" type="checkbox"/> (we) <input type="checkbox"/> (did not) view the body after death.					
22b. SIGNATURE		DEGREE	22c. DATE SIGNED		
Daniel V. Lindenstruth, M.D.		M.D.	1-23-85		
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS			
Daniel V. Lindenstruth, M.D.		c/o Maryland General Hospital			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION		
Cremation	Jan. 25, 1985	Westview	Catonsville, Balto. Md.		
24. FUNERAL DIRECTOR		25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE	
Leonard J. Ruck Inc. Baltimore, Maryland		JAN 24 1985		[Signature]	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use on the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked as item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

85 01479

REG. NO.

1. FOR  
STATE  
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) <b>HANNAH</b>			FIRST MIDDLE LAST <b>ROSEN</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>1-6-85</b>			2b. HOUR <b>505</b> AM		
3. SEX <b>FEMALE</b>			4. RACE <b>CAUCASIAN</b>			5. DATE OF BIRTH MONTH DAY YEAR <b>7 4 1896</b>			6. AGE (IN YEARS LAST BIRTHDAY) <b>88</b> YRS		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>BALTIMORE, MD</b>			7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH <b>BALTI CITY</b> MD.		
10. CITY OR TOWN OF DEATH <b>BALTIMORE</b>			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>LEVINDALE GERIATRIC CNTR</b>			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>HOUSEWIFE</b>			12b. KIND OF BUSINESS OR INDUSTRY <b>AT HOME</b>		
13a. STATE <b>MARYLAND</b>			13b. COUNTY			13c. CITY OR TOWN <b>BALTIMORE</b>			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
13e. STREET ADDRESS / ZIP CODE <b>6214 WALLIS AVE. #21215</b>			14. FATHER'S NAME FIRST MIDDLE LAST <b>HARRIS</b>			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>FRUMA SAPPERSTEIN</b>					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>NO</b>			16b. SOCIAL SECURITY NO. <b>213-01-1911</b>			17. INFORMANT <b>MERVIN ROSEN</b>			ADDRESS <b>6603 DORSAN CT. BALTO., MD 21209</b>		

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)  
PART I. DEATH WAS CAUSED BY:IMMEDIATE CAUSE (a) **- Aspiration pneumonia**

DUE TO, OR AS A CONSEQUENCE OF

(b)

DUE TO, OR AS A CONSEQUENCE OF

(c)

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: **perkinson's disease, AscVD, coronary Insufficiency**

19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>11 19</b>			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21i. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (1) (this hospital) attended the deceased from <b>11/14/80</b> to <b>1/6/85</b> , that (1) (we) last saw the deceased alive on <b>1/6/85</b> , and that in (my/our) opinion death occurred on the date and hour and from the causes stated above, (1) (we) (did) (did not) view the body after death.											
22b. SIGNATURE <b>[Signature]</b>			DEGREE <b>MD</b> ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22c. DATE SIGNED <b>1-6-85</b>					
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>KHIN-M. TUY</b>			22e. ADDRESS <b>Levindale Nursing Home Balto</b>								

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>BURIAL</b>		23b. DATE <b>JAN. 7, 1985</b>		23c. NAME OF CEMETERY OR CREMATORY <b>ANSHE NEISEN</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>ROSEDALE BALTO. MD</b>	
24. FUNERAL DIRECTOR NAME <b>SOL LEVINSON &amp; BROS., INC.</b> ADDRESS <b>6010 REISTERSTOWN RD. BALTO., MD 21215</b>				25a. DATE REC'D. BY REGISTRAR <b>JAN 11 1985</b>		25b. REGISTRAR'S SIGNATURE <b>[Signature]</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of once.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 states any injury, or other traumatic event, the medical examiner must be notified at once.

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(VRA 15, 4)

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH											
1- FOR STATE REGISTRAR					REG. NO.						
1 DECEASED NAME (TYPE OR PRINT)					2a DATE OF DEATH					2b HOUR	
FIRST MIDDLE LAST <b>DOROTHY ROSS</b>					MONTH DAY YEAR <b>JAN. 1, 1985</b>					11:30AM	
3 SEX		4 RACE		5. DATE OF BIRTH			6. AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YEAR MONTHS DAYS		
FEMALE		WHITE		JULY 12, DAY 1913			71		IF UNDER 24 HRS. HOURS MIN.		
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b CITIZEN OF WHAT COUNTRY?		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9 BALTIMORE CITY OR COUNTY OF DEATH				
OHIO		USA					BALTIMORE CITY MD.				
10 CITY OR TOWN OF DEATH		11 NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)						12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b KIND OF BUSINESS OR INDUSTRY	
BALTIMORE		JOHNS HOPKINS HOSPITAL						HOUSEWIFE		AT HOME	
13a STATE					13b CITY OR TOWN		13c STREET ADDRESS / ZIP CODE				
MARYLAND					BALTO.		7106 DEERFIELD RD. #21208				
14 FATHER'S NAME FIRST MIDDLE LAST					15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST						
UNKNOWN IREY					UNKNOWN						
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)					16b SOCIAL SECURITY NO.		17 INFORMANT				
NO					219-22-1315		DAVID ROSS ADDRESS 7106 DEERFIELD RD. BALTO., MD 21208				
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>CARDIORESPIRATORY ARREST</b>										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>time of death</b>	
DUE TO, OR AS A CONSEQUENCE OF (b) <b>BACTERIAL PERITONITIS</b>										10 days	
DUE TO, OR AS A CONSEQUENCE OF (c) <b>BLADDER CARCINOMA</b>										14 years	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a) <b>PRIMARY BILIARY CIRRHOSIS, MALNUTRITION</b>											
19a DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?	
NONE								YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21i. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from <b>12/21</b> , 19 <b>84</b> , to <b>1/1</b> , 19 <b>85</b> , that (I) (we) last saw the deceased alive on <b>1/1</b> , 19 <b>85</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE <b>Kenneth J. Holroyd</b>						DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED <b>1-1-85</b>			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>KENNETH J. HOLROYD</b>						22e. ADDRESS <b>JOHNS HOPKINS HOSPITAL 600 N. Wolfe St. BALTIMORE MD 21205</b>					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)			23b. DATE		23c. NAME OF CEMETERY OR CREMATORY			23d. LOCATION CITY OR TOWN COUNTY STATE			
BURIAL			JAN. 3, 1985		LIBERTY PARK			RANDALLSTOWN BALTO. MD			
24 FUNERAL DIRECTOR NAME						25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE			
SOL LEVINSON & BROS., INC. 6010 REISTERSTOWN RD. BALTO., MD 21215						JAN 9 1985		<i>Sol Levinson-Randall</i>			

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FIELD RD. BALTO. MD 21

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

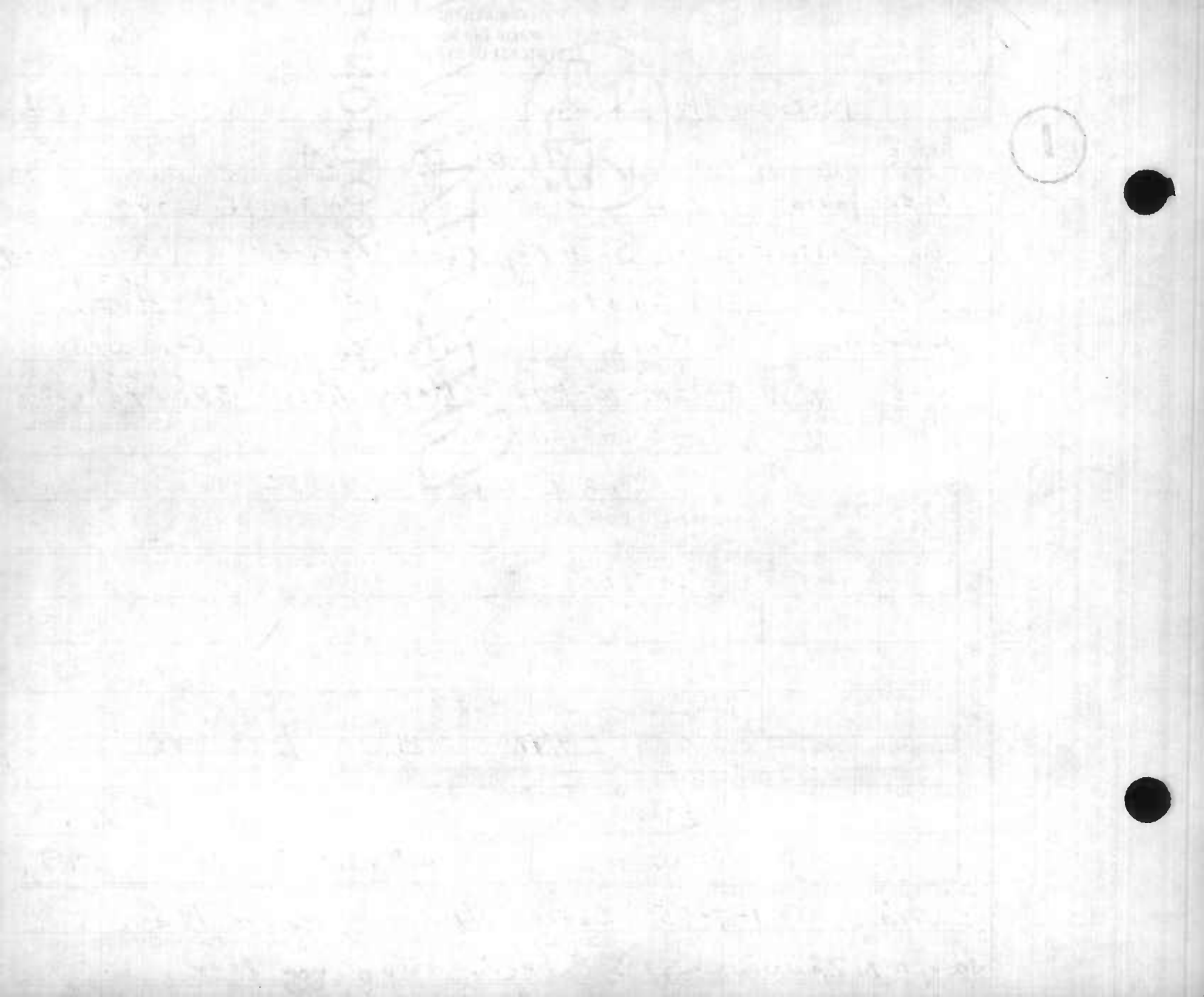
FOR  
STATE  
REGISTRAR

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) <b>NORMAN A. ROSSI</b>			2a. DATE OF DEATH MONTH <b>1</b> DAY <b>3</b> YEAR <b>85</b>			2b. HOUR <b>7:04 PM</b>	
3. SEX <b>MALE</b>		4. RACE <b>WHITE</b>		5. DATE OF BIRTH MONTH <b>7</b> DAY <b>09</b> YEAR <b>20</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>64</b> YRS	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>MARYLAND</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>BALTIMORE CITY</b> MD.	
10. CITY OR TOWN OF DEATH <b>Wd - Balto</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Francis Scott Key Med.</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Retired</b>	
13a. STATE <b>Md</b>		13b. COUNTY <b>Balto.</b>		13c. CITY OR TOWN <b>Balto.</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST <b>ANTONIO</b> MIDDLE <b>ROSSI</b> LAST <b>ROSSI</b>		15. MOTHER'S MAIDEN NAME FIRST <b>FILAMENA</b> MIDDLE <b>GIANNINO</b> LAST <b>GIANNINO</b>		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>YES</b> <b>W.W.II</b>			
16b. SOCIAL SECURITY NO. <b>217-05-1374</b>		17. INFORMANT ADDRESS <b>21224 3809 Fair Ave.</b>					
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>CARDIORESP ARREST</b>							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
DUE TO, OR AS A CONSEQUENCE OF (b) <b>CORONARY ARTERY DISEASE</b>							
DUE TO, OR AS A CONSEQUENCE OF (c)							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <b>DIABETES MELLITUS</b>							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. <b>19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME STREET FACTORY OFFICE FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <b>9/17</b> 19 <b>81</b> to <b>1/3</b> 19 <b>85</b> , that (I) (we) last saw the deceased <b>alive</b> on <b>1/3</b> 19 <b>85</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <b>C.T. MORROW MD</b>				DEGREE <b>MD</b>		22c. DATE SIGNED <b>1/3/85</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>C.T. MORROW, MD</b>				22e. ADDRESS <b>F.S. KEY MED CTR, EMERG DEPT,</b>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>1-7-85</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Sacred Heart</b>		23d. LOCATION CITY OR TOWN <b>Balto. Md.</b> COUNTY STATE	
24. FUNERAL DIRECTOR NAME <b>Joseph N. ZANNINO</b> ADDRESS <b>21224 263 S. Conkling</b>				25a. DATE REC'D. BY REGISTRAR 25b. REGISTRAR'S SIGNATURE <b>JAN 8 1985</b>			

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**STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH**

01482  
REG. NO.

1- FOR  
STATE  
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT)		FIRST		MIDDLE		LAST		2a. DATE KNOWN OF DEATH		ESTIMATED		MONTH		DAY		YEAR		2b. HOUR	
STAMATIOS						ROUCHOS		11		11		19		85				M	
3. SEX	4. RACE	5. DATE OF BIRTH		6. AGE (IN YEARS)		IF UNDER 1 YR.		IF UNDER 24 HRS.		7c. DATE PRONOUNCED DEAD		MONTH		DAY		YEAR		2d. HOUR	
M	W	Nov. 23, 1891		93 YRS.						1		11		19		85		10:50 a M	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED		NEVER MARRIED		WIDOWED		DIVORCED		9. BALTIMORE CITY OR COUNTY OF DEATH							
Greece		USA										Baltimore City						MD.	
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY													
Baltimore		Francis Scott Key Medical Center		Boxer		Steel Co.													
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET ADDRESS											
Md.				Baltimore		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		914 E. Lake Ave.										21212	
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME																	
Unk		Unk																	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES?		16b. SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS													
No		236 03 5962		Mr. George Manaras		914 E. Lake Ave.-12													

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY:		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
IMMEDIATE CAUSE (a) <u>Congestive heart failure</u>			
DUE TO, OR AS A CONSEQUENCE OF			
Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost.			
(b) <u></u>			
DUE TO, OR AS A CONSEQUENCE OF			
(c) <u></u>			
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 a			
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?	
20. AUTOPSY?			
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR	
		P.M. 19	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)	
21f. LOCATION STREET		CITY OR TOWN	
21g. COUNTY		STATE	
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .			
ACTUAL SIGNATURE		TITLE (SPECIFY)	
		M.D. Assistant	
EXAMINER'S NAME (TYPE OR PRINT)		DATE SIGNED	
Ann M. Dixon, M.D.		1-11-85	
ADDRESS			
111 Penn St., Balto., Md. 21201			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE	
Burial		1/14/85	
23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN	
Greek Orthodox Church		Baltimore, Md.	
24. FUNERAL DIRECTOR NAME		25a. DATE REC'D. BY REGISTRAR	
MITCHELL-WIEDEFELD HOME, INC.		JAN 16 1985	
ADDRESS		REGISTRAR'S SIGNATURE	
6500 York Rd.			

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DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGES 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 24 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.



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STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

FOR  
1 - STATE  
REGISTRAR

REG. NO.

1 DECEASED NAME (TYPE OR PRINT) <b>GREGORY L. ROYAL</b>			2a DATE OF DEATH MONTH DAY YEAR <b>JANUARY 4, 1985</b>		2b HOUR <b>12:17 P</b>	
3 SEX <b>male</b>	4 RACE <b>black</b>	5 DATE OF BIRTH MONTH DAY YEAR <b>1 28 60</b>		6 AGE (IN YEARS LAST BIRTHDAY) <b>24</b> YRS.		
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Maryland</b>	7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>BALTIMORE CITY</b> MD.		
10 CITY OR TOWN OF DEATH <b>BALTIMORE</b>	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>JOHNS HOPKINS HOSPITAL</b>			12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		
12b KIND OF BUSINESS OR INDUSTRY						
13a. STATE <b>Maryland</b>			13b. COUNTY <b>Baltimore</b>		13c. CITY OR TOWN <b>Baltimore</b>	
14 FATHER'S NAME FIRST MIDDLE LAST <b>Robert Bell</b>			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Betty Royal</b>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>No</b>		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) <b>216-76-8248</b>		17. INFORMANT ADDRESS <b>Ethel Royal 2554 Aisquith Street</b>		
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>HEPATIC FAILURE</b>					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>2 weeks</b>	
DUE TO, OR AS A CONSEQUENCE OF (b) <b>FULMINANT HEPATITIS B</b>					<b>1 month</b>	
DUE TO, OR AS A CONSEQUENCE OF (c) <b>INTRAVENOUS DRUG ABUSE</b>					<b>4 years</b>	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)						
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>						
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)		
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE		
22a. I certify that (I) (this hospital) attended the deceased from <b>20 DECEMBER 19 84</b> to <b>4 JANUARY 19 85</b> , that (I) (we) last saw the deceased alive on <b>4 January 19 85</b> , and that in my (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.						
22b. SIGNATURE <b>Craig W. Hendrix</b>		DEGREE <b>ATTENDING PHYSICIAN</b> <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED <b>4 JANUARY 1985</b>		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>CRAIG W. HENDRIX</b>		22e. ADDRESS <b>608 N. WOLFE ST., BALTIMORE, MD</b>				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>BURIAL</b>		23b. DATE <b>1/10/85</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Baltimore Cemetery</b>		
23d. LOCATION CITY OR TOWN COUNTY STATE <b>Baltimore, Md</b>						
24 FUNERAL DIRECTOR NAME <b>Wm C March F/H, Inc. 1101 E North Avenue</b>				25a. DATE REC'D. BY REGISTRAR <b>JAN 7 1985</b>		
25b. REGISTRAR'S SIGNATURE						

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Post-mortem examination, autopsy, or other procedure must be notified of once retained by the hospital, or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral home, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death.

IMPORTANT: If item 21 is marked or item 18 shows any injury or other traumatic event, the medical examiner must be notified of once retained by the hospital, or attending physician.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 4 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1- STATE REGISTRAR		DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH		REG. NO.	
1. DECEASED NAME (TYPE OR PRINT) <b>LEON Winfred RIX</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>1-4-85</b>		2b. HOUR <b>1:15 PM</b>
3. SEX <b>Male</b>	4. RACE <b>White</b>	5. DATE OF BIRTH MONTH DAY YEAR <b>July 19, 1902</b>		6. AGE (IN YEARS LAST BIRTHDAY) YRS MONTHS DAYS <b>82</b>	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Maine</b>	7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Baltimore City</b> MD.	
10. CITY OR TOWN OF DEATH <b>Baltimore</b>	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Mason Lord Nursing Home</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Open Hearth</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Steel Mfgr.</b>
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13b. STATE <b>Maryland</b> 13c. COUNTY <b>Balto.</b> 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> 13e. STREET ADDRESS / ZIP CODE <b>101 Center Pl. Apt. 417 21222</b>					
14. FATHER'S NAME FIRST MIDDLE LAST <b>John Rix</b>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Minnie Kearney</b>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>Yes</b>		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) <b>WW I 231.05.3318</b>		17. INFORMANT ADDRESS <b>Emily L. Rix (Wife) (Same as 13e)</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>CARDIOpulmonary arrest</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>SEPSIS</b> DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a) _____					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from <b>1/4/27</b> 19 <b>84</b> to <b>1/4</b> 19 <b>85</b> , that (I) (we) last saw the deceased alive on <b>1/4</b> 19 <b>85</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE <b>Bruce Waldholtz</b>				22c. DATE SIGNED <b>1/4/85</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>BRUCE WALDHOLTZ</b>				22e. ADDRESS <b>4940 EASTERN AVE. Balt. Md. 21224</b>	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Cremation</b>		23b. DATE <b>1/5/1985</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Green Mount Crematory</b>	
23d. LOCATION CITY OR TOWN COUNTY STATE <b>Baltimore Maryland</b>					
24. FUNERAL DIRECTOR <b>Walter Brooks Bradley Inc., Dundalk Md. 21222</b>				25a. DATE REC'D. BY REGISTRAR <b>JAN 7 1985</b>	
				25b. REGISTRAR'S SIGNATURE <b>Lia Davidson-Randall</b>	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 1 and 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 3 and 4 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked as item 18, shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <b>HARRISON G. ROCK</b>		2a. DATE OF DEATH MONTH DAY YEAR <b>1-26-85</b>		2b. HOUR MIN. <b>11:45 A.M.</b>	
3. SEX <b>M</b>	4. RACE <b>AA 2</b>	5. DATE OF BIRTH MONTH DAY YEAR <b>5-31-1920</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>64</b> YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>M.D.</b>	7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>BALTIMORE</b> MD.	
10. CITY OR TOWN OF DEATH <b>BALTO. CITY</b>	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>LUTHERAN HOSPITAL</b>		12a. USUAL OCCUPATION (TYPE WORK FOLLOWED MOST OF WORKING LIFE) <b>RETIRED</b>		12b. KIND OF BUSINESS OR INDUSTRY
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE <b>M.D.</b>			13b. COUNTY <b>BALTIMORE</b>		
13c. CITY OR TOWN <b>BALTO. CITY</b>			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
13e. STREET ADDRESS / ZIP CODE <b>1411 W. CENTER ST. BALTO. MD. 21201</b>					
14. FATHER'S NAME FIRST MIDDLE LAST <b>WILLIAM ROCK</b>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>LOLA WINDEK</b>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES NO OR UNKNOWN) <b>0</b>		16b. SOCIAL SECURITY NO. <b>142-12-8196</b>		17. INFORMANT ADDRESS <b>ALLEN ROCK, 1411 W. CENTER ST. BALTO. MD</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Shock</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>Anemia</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF (c) <b>GI bleeding</b>					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a). <b>Diabetes mellitus</b>					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)	
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from <b>1-18-85</b> to <b>1-26-85</b> , that (I) (we) last saw the deceased alive on <b>1-26-85</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE <b>BICH T DUONG</b>		DEGREE <b>M.D.</b>		22c. DATE SIGNED <b>1-26-85</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>BICH T DUONG</b>		22e. ADDRESS <b>LUTHERAN HOSPITAL</b>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>2-2-85</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Grace</b>	
23d. LOCATION CITY OR TOWN COUNTY STATE <b>Wheaton-Somerset Md</b>		23e. DATE REC'D. BY REGISTRAR <b>FEB 05 1985</b>		23f. REGISTRAR'S SIGNATURE <b>John Davidson-Randall</b>	
24. FUNERAL DIRECTOR NAME ADDRESS <b>Addie James, 407 Somers Ave. Pr. Ave. Md</b>					

BP





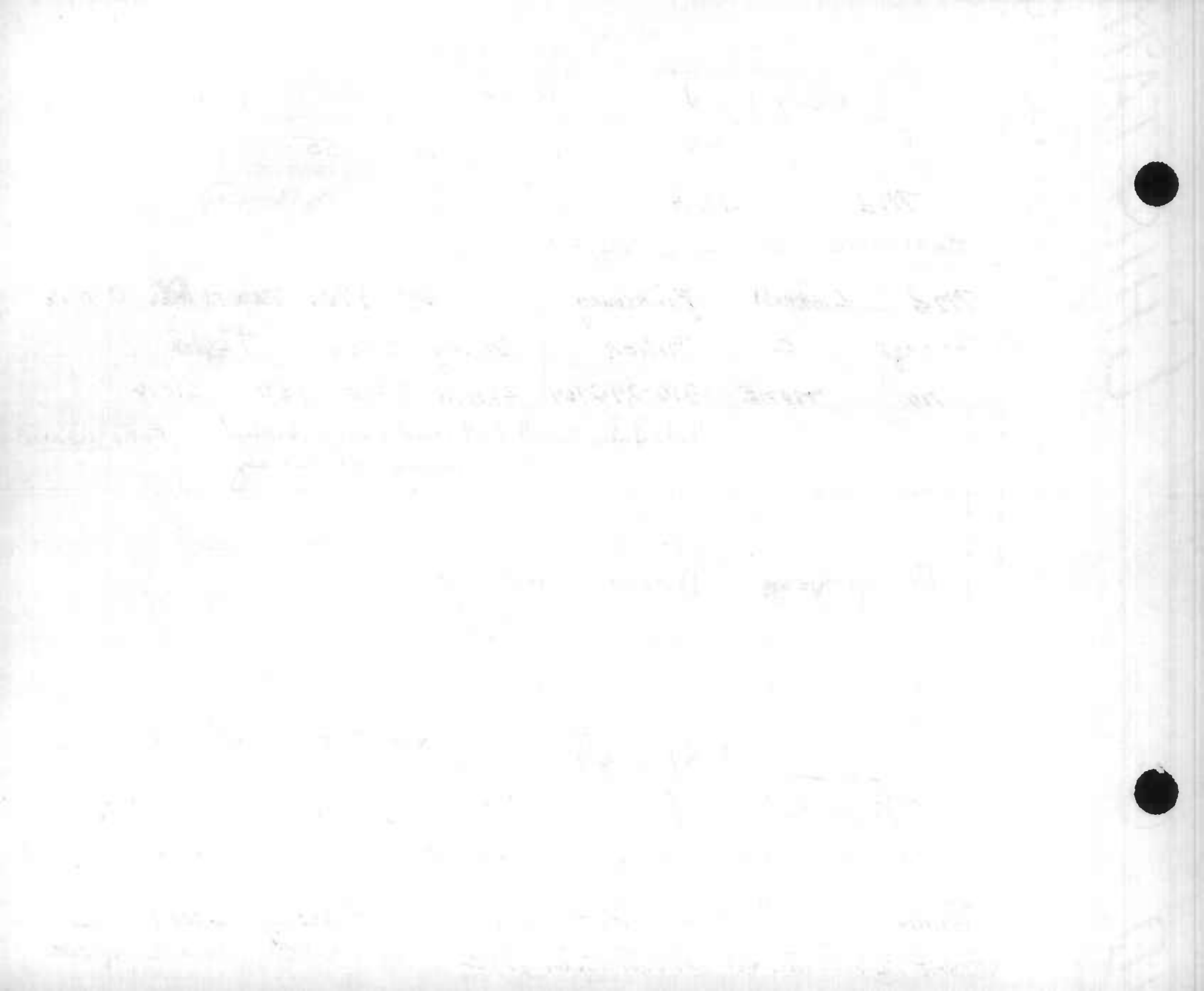
**STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH**

REG. NO.

1. DECEASED NAME (TYPE OR PRINT)		FIRST	MIDDLE	LAST	2a. DATE OF DEATH	MONTH	DAY	YEAR	2b. HOUR
Mary			V.	Rose	1	28	85	9:10 PM	
1. SEX	F	4. RACE	W	5. DATE OF BIRTH	6. AGE (IN YEARS LAST BIRTHDAY)	IF UNDER 1 YEAR		IF UNDER 24 HRS.	
				MONTH DAY YEAR	55	MONTHS	DAYS	HOURS	MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH					
MD	USA			Balto. Cty. MD.					
10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY		
Baltimore	Baltimore County General								
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)					13b. INSIDE CITY LIMITS?				
13a. STATE					YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
13a. CITY OR TOWN		13c. CITY OR TOWN		13d. STREET ADDRESS / ZIP CODE					
MD		Finksburg		3701 TUNER Rd. 21048					
14. FATHER'S NAME					15. MOTHER'S MAIDEN NAME				
FIRST MIDDLE LAST					FIRST MIDDLE LAST				
George C. Miller					Mary Ellen Taylor				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)					16b. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS		
NO					NONE		Arnold Rose 13E 21048		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)									
PART I. DEATH WAS CAUSED BY:									
IMMEDIATE CAUSE (a) Metastatic Small Cell Undifferentiated									
DUE TO, OR AS A CONSEQUENCE OF Carcinoma of Lung									
(b)									
DUE TO, OR AS A CONSEQUENCE OF									
(c)									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 11a									
Paraplegia Brain metastases									
19a. DATE OF OPERATION					19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?	
								YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?					YES <input type="checkbox"/> NO <input type="checkbox"/>				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)					21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)		
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK					21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE		
22a. I certify that (I) (this hospital) attended the deceased from October 1984, to January 28 1985, that (I) (we) last saw the deceased alive on 1/28/85, 1985, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					22b. SIGNATURE Marshall A. Levine MD			22c. DATE SIGNED 1/28/85	
22d. PHYSICIAN'S NAME (TYPE OR PRINT)					22e. ADDRESS				
Marshall A. Levine					711 W. 40th St. Baltimore, MD				
23a. BURIAL, CREMATION, REMOVAL		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION			
Burial		2-1-85		Evergreen		Finksburg Carroll MD			
24. FUNERAL DIRECTOR					25. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE		
Robert Kyle Britts Jr. Westminster, Md					FEB 04 1985		John Davidson-Randall		

MEDICAL CERTIFICATION

BP \_\_\_\_\_



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										REG. NO.	
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST KENNETH W. RUDOLPH										2a. DATE KNOWN OF DEATH MONTH DAY YEAR 1-25-85 19	
3. SEX M	4. RACE WHITE	5. DATE OF BIRTH MONTH DAY YEAR 2-2-1909 75 YRS.	6. AGE (IN YEARS) LAST BIRTHDAY MONTHS DAYS HOURS MIN	IF UNDER 1 YR	IF UNDER 24 HRS.	7c. DATE PRONOUNCED DEAD MONTH DAY YEAR 1-25-85 19		2d. HOUR 8:46 AM			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MD.		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD.					
10. CITY OR TOWN OF DEATH Baltimore		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 502 S. Ellwood Avenue 21224				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) RETIRED		12b. KIND OF BUSINESS OR INDUSTRY DRAFTSMAN			
13a. STATE MD.		13b. COUNTY		13c. CITY OR TOWN BALTO.		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 502 S. ELLWOOD AVE. 21224			
14. FATHER'S NAME FIRST MIDDLE LAST UNKNOWN				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST UNKNOWN							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO				16b. SOCIAL SECURITY NO. 212-05-7396		17. INFORMANT ADDRESS JOHANNA RUDOLPH SAME.					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Arteriosclerotic cardiovascular disease</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: <u>Natural causes</u> <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .											
ACTUAL SIGNATURE <u>Margie Meyhell</u>				TITLE (SPECIFY) M.D. Assistant MEDICAL EXAMINER				DATE SIGNED 1-26-85			
EXAMINER'S NAME (TYPE OR PRINT) Margarita A. Korell, M.D.				ADDRESS 111 Penn Street							
23a. BURIAL, CREMATION, REMOVAL (IF)		23b. DATE 1-29-85		23c. NAME OF CEMETERY OR CREMATORY OAKLAWN CEM.		23d. LOCATION CITY OR TOWN COUNTY STATE BALTO. MD.					
24. FUNERAL DIRECTOR NAME HOFFMANN-SKARDA ADDRESS 3218 HUDSON ST.						25a. DATE REC'D. BY REGISTRAR JAN 29 1985		25. REGISTRAR'S SIGNATURE Julia Davidson-Randall			

50% COTTON FIBER

UNION MILITARY



STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

8:45 PM

1 - FOR  
STATE  
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT)		2a. DATE OF DEATH		2b. HOUR	
MARtha Ruffin		1-10-85		9 PM	
3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (IN YEARS, LAST BIRTHDAY)	IF UNDER 1 YEAR MONTHS DAYS	
FEMALE	BLACK	9 20 01	83		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH		
UNKNOWN	U.S.		BALTIMORE City MD.		
10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY
BALTIMORE	KENSON N. HOME				
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)	13b. STATE	13c. COUNTY	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET ADDRESS	13f. ZIP CODE
BALTIMORE				2914 Arunah Ave	21216
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME			
- UNKNOWN -		- UNKNOWN -			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)	16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES)	17. INFORMANT		ADDRESS	
	813-76-2714	Mrs. Evelyn Banks		8914 Arunah Ave.	

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CARDIO PULMONARY ARREST</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Dementia &amp; Chronic Alcoholism</u> DUE TO, OR AS A CONSEQUENCE OF (c) _____		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
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PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: \_\_\_\_\_

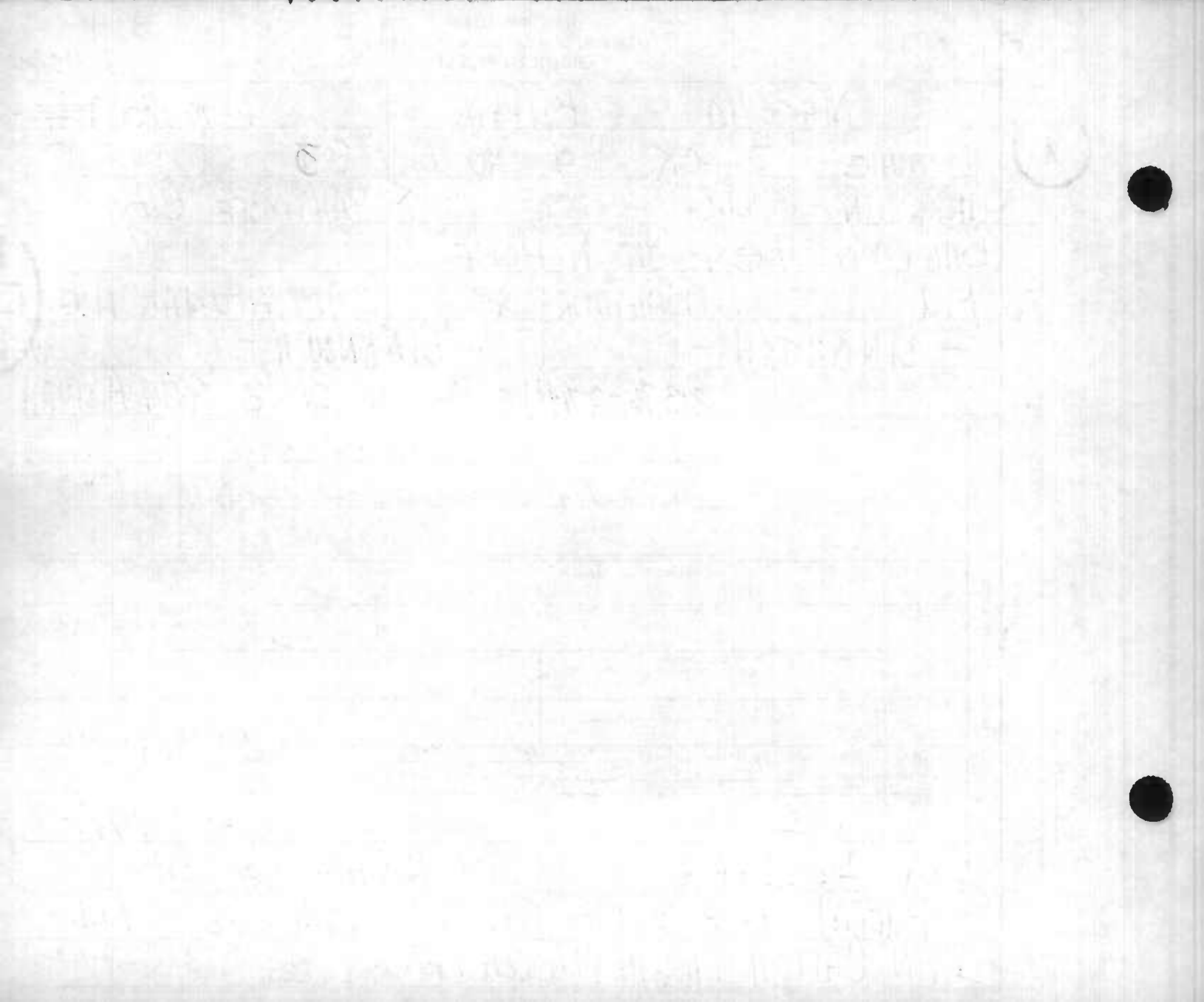
19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from <u>8-8</u> , 19 <u>73</u> , to <u>1-10</u> , 19 <u>85</u> , that (I) (we) lost saw the deceased alive on <u>1-10</u> , 19 <u>85</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.			
22b. SIGNATURE <u>Aslak</u>	DEGREE	22c. DATE SIGNED <u>1/11/85</u>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <u>Dr. G. SHAH</u>		22e. ADDRESS <u>2105 N. Charles St.</u>	

23a. BURIAL, CREMATION, REMOVAL	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION CITY OR TOWN COUNTY STATE
BURIAL	1-18-85	Me. Auburn	BALTIMORE Md.
24. FUNERAL DIRECTOR NAME	24b. ADDRESS	24c. DATE REC'D. BY REGISTRAR	24d. REGISTRAR'S SIGNATURE
Irvin Carroll	1712-14 N. North Ave	JAN 14 1985	J. Davidson-Rendell

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.



STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

85 01489

FOR  
1 - STATE  
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Melvin J. Rupinski			2a. DATE OF DEATH MONTH DAY YEAR 1 25 85		2b. HOUR 6:55 A
3. SEX Male	4. RACE White	5. DATE OF BIRTH MONTH DAY YEAR 1 23 19		6. AGE (IN YEARS LAST BIRTHDAY) 66 YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MD	7b. CITIZEN OF WHAT COUNTRY? USA	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH City MD.	
10. CITY OR TOWN OF DEATH Baltimore	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) University of Md Hosp.		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Retiree		12b. KIND OF BUSINESS OR INDUSTRY
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE 13b. COUNTY 13c. CITY OR TOWN md city			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
14. FATHER'S NAME FIRST MIDDLE LAST Theodor Rupinski			15. MOTHER'S MAIDEN NAME FIRST MIDDLE Wanda Sadlowski		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) yes			16b. SOCIAL SECURITY NO. 29-05-7578		
17. INFORMANT Julia Rupinski			ADDRESS 1431 Cooksre St. 21230		
18. CAUSE OF DEATH (Enter only one cause on line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a). Cardiopulmonary arrest DUE TO, OR AS A CONSEQUENCE OF (b). Multiple system disease DUE TO, OR AS A CONSEQUENCE OF (c). Approximate interval between onset and death 1 hour 14 days					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (1) (this hospital) attended the deceased from 1/2 19 85, to 1/25 19 85, that (1) (we) last saw the deceased alive on 1/25/85, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (1) (we) (did) (did not) view the body after death.					
22b. SIGNATURE Gregg J. Fromell		DEGREE MD		22c. DATE SIGNED 1/25/85	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Gregg J. Fromell		22e. ADDRESS Univ. Md. Hosp 225 Green St., Balt.			
23a. BURIAL, CREMATION, REMOVAL (CITY) Burial		23b. DATE 1/28/85		23c. NAME OF CEMETERY OR CREMATORY Holy Rosary Cem.	
23d. LOCATION CITY OR TOWN COUNTY Baltimore		23e. DATE REC'D. BY REGISTRAR JAN 28 1985			
23f. FUNERAL DIRECTOR NAME Charles S. Steiner		23g. REGISTRAR'S SIGNATURE Julia Davidson-Randall			

BP

DHMH - 16 50M 4/83  
(VRA 15, 4)

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 1 and 2 should be detached for use at the burial/cremation. Then please remove carbon papers. Pages 3 and 4 should be filed with 72 hours after death in the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.





STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

85 01490

1 - FOR  
STATE  
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) <b>John Benjamin Rustic</b>				2a. DATE OF DEATH MONTH DAY YEAR <b>1-29-85</b>		2b. HOUR <b>2 AM</b>	
3. SEX <b>Male</b>		4. RACE <b>White</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>10-9-22</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>62</b> YRS.	
7a. BIRTHPLACE COUNTRY <b>Baltimore, Maryland</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Baltimore City</b> MD.	
10. CITY OR TOWN OF DEATH <b>Baltimore</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>St. Agnes Hospital</b>		12. USUAL OCCUPATION (GIVE MOST OF WORKING LIFE) <b>Repairman</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>C &amp; P TelCo.</b>	
13a. STATE <b>Maryland</b>		13b. COUNTY <b>Baltimore</b>		13c. CITY OR TOWN <b>Catonsville</b>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
13e. STREET ADDRESS / ZIP CODE <b>712 Ingleside Ave. 21228.</b>		14. FATHER'S NAME FIRST MIDDLE LAST <b>John Leroy Rustic</b>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Edna B. O'Brien</b>		16. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) <b>Yes WW II</b>	
16b. SOCIAL SECURITY NO. <b>217-18-9546</b>		17. INFORMANT <b>Mrs. Ruby M. Rustic</b>		17b. ADDRESS <b>712 Ingleside Ave.</b>		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Prostatic Carcinoma metastasis</b> DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <b>1/28</b> , 19 <b>85</b> , to <b>1/29</b> , 19 <b>85</b> , that (I) (we) last saw the deceased alive on <b>1/29</b> , 19 <b>85</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <b>John P. Lavery</b>				DEGREE <b>MD</b> ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <b>1/29/85</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>JOHN P. LAVERY</b>				22e. ADDRESS <b>St Agnes Hospital, Baltimore MD.</b>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>2/1/85</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Lake View Mem. Park-Sykesville, Maryland</b>		23d. LOCATION CITY OR TOWN COUNTY STATE	
24. FUNERAL DIRECTOR NAME ADDRESS <b>Sterling Funeral Estate, P.A. 736 Edmondson Ave.; Catonsville, Md. 21228</b>				25a. DATE RECEIVED BY REGISTRAR <b>JAN 31 1985</b>			

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STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

85 01491

1- FOR  
STATE  
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) Henry (HARRY) J. Ruth				2a. DATE OF DEATH MONTH DAY YEAR 1 9 85				2b. HOUR 5:15 PM	
3 SEX MALE		4 RACE White		5. DATE OF BIRTH MONTH DAY YEAR 4 28 22		6 AGE (IN YEARS LAST BIRTHDAY) 62 YRS.		7. IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD.			
10 CITY OR TOWN OF DEATH Baltimore		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) St. Agnes Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) USGov.		12b. KIND OF BUSINESS OR INDUSTRY D.F. DsPT.	
13a. STATE MD		13b. COUNTY Howard		13c. CITY OR TOWN Ellicott City		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 3203 Chatham Rd. 21043	
14. FATHER'S NAME FIRST MIDDLE LAST Herman T. Ruth		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Mary E. O'Connor		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. 216-16-3250		17. INFORMANT June Ruth 3203 Chatham Rd.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Respiratory &amp; Cardiac Arrest</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Small Bowel Obstruction</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Metastatic Rectal CA</u> PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a									
19a. DATE OF OPERATION 12-25-84		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED Small Bowel Obstruction				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE Craig A Cole MD				DEGREE MD ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>				22c. DATE SIGNED 1-9-85	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Craig A Cole MD				22e. ADDRESS ST. AGNES HOSPITAL					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		23b. DATE Jan 12, 1985		23c. NAME OF CEMETERY OR CREMATORY New Cathedral		23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore Maryland			
24. FUNERAL DIRECTOR NAME Evans Chapel of Memories Harford Rd.				25a. DATE REC'D. BY REGISTRAR 8800 JAN 16 1985		25b. REGISTRAR'S SIGNATURE [Signature]			

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpages. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked as item 18 above any injury, or other traumatic event, any medical conditions must be certified as such.

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FOR  
1 - STATE  
REGISTRARDEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <b>Marie C. Sacco</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>January 15, 1985</b>		2b. HOUR M <b></b>
3. SEX <b>Female</b>	4. RACE <b>White</b>	5. DATE OF BIRTH MONTH DAY YEAR <b>Oct. 8 1904</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>80</b>	IF UNDER 1 YEAR MONTHS DAYS <b></b>
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Pennsylvania</b>	7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Baltimore City, MD.</b>	
10. CITY OR TOWN OF DEATH <b>Baltimore</b>	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>4405 Mainfield Ave.</b>			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Ret. - Martin Marietta</b>	
13a. STATE <b>Maryland</b>			13b. COUNTY <b>Baltimore</b>	13c. CITY OR TOWN <b>Baltimore</b>	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
14. FATHER'S NAME FIRST MIDDLE LAST <b>Frank Sacco</b>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Carmella Vitale</b>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>No</b>		16b. SOCIAL SECURITY NO. <b>207-05-2792</b>		17. INFORMANT ADDRESS <b>Mr. Bernard Custodero Same as # 13e</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cardiorespiratory arrest</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) <b>Severe emphysema &amp; COPD</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>Alzheimer's disease</b>					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>5 min</b> <b>5 yrs</b> <b>10 yrs</b>
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: a					
19a. DATE OF OPERATION <b>none</b>		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED <b></b>		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18: PART I OR PART 2) <b>NA</b>	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) <b></b>		21f. LOCATION STREET CITY OR TOWN COUNTY STATE <b></b>	
22a. I certify that (I) (this hospital) attended the deceased from <b>Jan 11</b> 19 <b>85</b> , to <b>Jan 11</b> 19 <b>85</b> , that (I) (we) lost saw the deceased alive on <b>Jan 11</b> 19 <b>85</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE <b>Mary Newman</b>		DEGREE <b>MD</b>		22c. DATE SIGNED <b>1-16-85</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>Dr. Mary Newman</b>		22e. ADDRESS <b>9 E. Chase St. Baltimore, Md.</b>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>1-18-85</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Holy Redeemer</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Baltimore, Maryland</b>
24. FUNERAL DIRECTOR NAME <b>Leonard J. Ruck, Inc.</b>		ADDRESS <b>Baltimore, Md.</b>		25a. DATE REC'D. BY REGISTRAR <b>JAN 18 1985</b>	25b. REGISTRAR'S SIGNATURE <b>[Signature]</b>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

January 12, 1985

cc

Dec. 10, 1984

White

Female

Belmont, N.Y.

U.S.A.

Belmont, N.Y.

Ref. - Belmont, N.Y.

Belmont, N.Y.

Belmont, N.Y.

1000 Belmont Ave. 10011

Belmont, N.Y.

White

Female

White

Female

1000 Belmont Ave. 10011

cc

Belmont, N.Y.

Belmont, N.Y.

1-1-85

Female

1000 Belmont Ave.

Belmont, N.Y.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers, Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of price.

1- FOR  
STATE  
REGISTRAR

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1 DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <b>MILTON Sahn</b>		2a DATE OF DEATH MONTH DAY YEAR <b>JANUARY 4, 1985</b>		2b HOUR <b>3:15</b> <sup>PM</sup>	
3 SEX <b>Male</b>		4 RACE <b>Cauc.</b>		5 DATE OF BIRTH MONTH DAY YEAR <b>11 19 1902</b>	
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Md.</b>		7b CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		6 AGE (IN YEARS LAST BIRTHDAY) <b>82</b> YRS.	
10 CITY OR TOWN OF DEATH <b>Baltimore</b>		11 NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Church Hospital</b>		9 BALTIMORE CITY OR COUNTY OF DEATH <b>Baltimore City</b> MD.	
12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Fireman</b>		12b KIND OF BUSINESS OR INDUSTRY <b>Steel</b>			
13a STATE <b>Md.</b>		13b COUNTY		13c CITY OR TOWN <b>Baltimore</b>	
14 FATHER'S NAME FIRST MIDDLE LAST <b>Frederick Sahn</b>		15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Ella Hurley</b>		13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>No</b>		16b SOCIAL SECURITY NO. <b>215-03-8385</b>		17 INFORMANT ADDRESS <b>Angela Sahn 2717 E. Fayette St.</b>	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>RESPIRATORY FAILURE</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>CHRONIC OBSTRUCTIVE PULMONARY DISEASE</b> DUE TO, OR AS A CONSEQUENCE OF (c)					
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)					
19a DATE OF OPERATION		19b CONDITION FOR WHICH OPERATION WAS PERFORMED		20a AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)	
21d INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f LOCATION STREET CITY OR TOWN COUNTY STATE	
22a I certify that (a) (this hospital) attended the deceased from <b>DECEMBER 31, 1984</b> to <b>JANUARY 4, 1985</b> , that (b) (we) lost <b>saw the deceased</b> on <b>JANUARY 4, 1985</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (If we did not view the body after death, so state.)					
22b SIGNATURE <i>[Signature]</i>		DEGREE		22c DATE SIGNED <b>JANUARY 4, 1985</b>	
22d PHYSICIAN'S NAME (TYPE OR PRINT) <b>DOCTOR IMPAGLIATELLI WALKER</b>		22e ADDRESS <b>CHURCH HOSPITAL 100 NORTH BROADWAY BALTIMORE Md 21231</b>			
23a BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b DATE <b>1/7/85</b>		23c NAME OF CEMETERY OR CREMATORY <b>New Cathedral Cem. Baltimore Md</b>	
24 FUNERAL DIRECTOR NAME <b>B. Dabrowski &amp; Son</b>		ADDRESS <b>2818 E. Baltimore St.</b>		25a DATE REC'D. BY REGISTRAR <b>JAN 7 1985</b>	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. If removed before the funeral, the permit will be void. The funeral director must file this with the State Dept. of Health and Mental Hygiene. (Section 10-101, Code of Regulations, Annotated, Maryland, 1981)

IMPORTANT: If item 21 is marked or item 18 is checked, the medical examiner must be notified at once.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH  |  |  |  |   |  |   |  |   |  |
|---|--|--|--|---|--|---|--|---|--|
| 1- FOR STATE REGISTRAR  |  |  |  |   |  |   |  |   |  |
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br><b>BESSIE L SALISBURY</b>  |  |  |  |   |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>01 04 85</b>  |  | 2b. HOUR<br><b>7:30PM</b>   |  |
| 3. SEX<br><b>female</b>   |  | 4. RACE<br><b>Black</b>  |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>3/1/1937</b>   |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>47</b> YRS  |  | IF UNDER 1 YEAR<br>MONTHS DAYS HOURS MIN.<br><b>0 0 0 0</b>   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Va.</b>   |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>  |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>BALTIMORE CITY</b> MD.                               |  |   |  |
| 10. CITY OR TOWN OF DEATH<br><b>BALTIMORE</b>   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>THE JOHNS HOPKINS HOSPITAL</b> |  |   |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)                                |  | 12b. KIND OF BUSINESS OR INDUSTRY   |  |
| 13a. STATE<br><b>Md</b>   |  | 13b. COUNTY<br><b>none</b>   |  | 13c. CITY OR TOWN<br><b>Baltimore</b>   |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 13e. STREET ADDRESS / ZIP CODE<br><b>2034 Robb Street 21218</b>   |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Sidney Clark</b>   |  |  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Fannie Fitch</b>  |  |   |  |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)  |  |  |  | 16b. SOCIAL SECURITY NO.  |  | 17. INFORMANT ADDRESS<br><b>Bernie Reed, 2034 Robb St. Baltimore, Md</b>                        |  |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY<br>IMMEDIATE CAUSE (a) <b>Hypovolemia / Cardiac Arrest</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(b) <b>Exsanguinating Hemorrhage</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <b>Recurrent Abdominal Septal Defect Repair</b> |  |  |  |   |  |   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>60 MINUTES</b><br><b>2 HOURS</b><br><b>2 hr</b>                                    |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: <b>none</b>  |  |  |  |   |  |   |  |   |  |
| 19a. DATE OF OPERATION<br><b>1/4/85</b>   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED<br><b>Abdominal Septal Defect / Anomalous Vessels Return</b>                                  |  |   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>            |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)  |  |   |  |   |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |   |  |   |  |
| 22a. I certify that (I (this hospital) attended the deceased from <b>Dec 31 1984</b> to <b>Jan. 4 1985</b> that (I (we) last saw the deceased alive on <b>Jan 4 1985</b> and that in (my (our) opinion death occurred on the date and hour and from the causes stated above, (I (we) (did) (did not) view the body after death.   |  |  |  |   |  |   |  |   |  |
| 22b. SIGNATURE<br><b>Walter M. Morgan, III MD</b>   |  |  |  | DEGREE<br><b>MD</b>   |  |   |  | 22c. DATE SIGNED<br><b>1-4-85</b>   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>Walter M. Morgan, III MD</b>  |  |  |  | 22e. ADDRESS<br><b>Johns Hopkins Hospital - Baltimore</b>   |  |   |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>Buried</b>  |  | 23b. DATE<br><b>1/10/85</b>  |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Garrison Forest Va Cemetery</b>  |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Owings Mills Md</b>                            |  |   |  |
| 24. FUNERAL DIRECTOR<br>NAME ADDRESS<br><b>Law Funeral Home 4611 Park Heights Ave. 21215</b>  |  |  |  | 25a. DATE REC'D. BY REGISTRAR<br><b>JAN 18 1985</b>   |  | 25b. REGISTRAR'S SIGNATURE<br><b>Arthur R. Rouse</b>  |  |   |  |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>MARGARET MARY SALISBURY CERTIFICATE OF DEATH   |  |   |  |   |                                     |   |                    |  |  |
|--|--|---|--|---|-------------------------------------|---|--------------------|--|--|
| 1. FOR STATE REGISTRAR   |  |   |  |   | REG. NO.                            |   |                    |  |  |
| 1. DECEASED NAME (TYPE OR PRINT)<br>MARGARET M. Salisbury  |  |   |  |   | 2a. DATE OF DEATH<br>January 16 '85 |   | 2b. HOUR<br>939 PM |  |  |
| 3. SEX<br>Female   |  | 4. RACE<br>White  |  | 5. DATE OF BIRTH<br>2 11 27   |                                     | 6. AGE (IN YEARS LAST BIRTHDAY)<br>57 YRS   |                    | 7. IF UNDER 1 YEAR<br>MONTHS DAYS HOURS MIN.   |  |
| 8a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Maryland  |  | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.A.  |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |                                     | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Baltimore City MD.                                      |                    |  |  |
| 10. CITY OR TOWN OF DEATH<br>Baltimore   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>Francis Scott Key Medical Center |  |   |                                     | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Housewife                   |                    | 12b. KIND OF BUSINESS OR INDUSTRY<br>Home Maker  |  |
| 13a. STATE<br>Maryland   |  | 13b. COUNTY<br>Baltimore  |  | 13c. CITY OR TOWN<br>Baltimore  |                                     | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |                    | 13e. STREET ADDRESS / ZIP CODE<br>3229 Elliott Street 21224  |  |
| 14. FATHER'S NAME<br>Fred Walters  |  |   |  | 15. MOTHER'S MAIDEN NAME<br>Lillian Doenges   |                                     |   |                    |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) No.   |  |   |  | 16b. SOCIAL SECURITY NO.<br>216-28-2627   |                                     | 17. INFORMANT<br>George L. Salisbury  |                    |  |  |
|  |  |   |  | ADDRESS<br>Same as 13e  |                                     |   |                    |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) Cardiorespiratory arrest<br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) Hypertension / arrhythmias<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) Myocardial infarction<br>PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a) |  |   |  |   |                                     |   |                    |  |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  |   |                                     | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>                       |                    | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)  |                                     |   |                    |  |  |
| 21d. INJURY OCCURRED<br>WHERE <input type="checkbox"/> AT HOME <input type="checkbox"/> INCH WHITE <input type="checkbox"/> AT WORK  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |                                     |   |                    |  |  |
| 22a. I certify that (this hospital) attended the deceased from 12/24 1984 to 1/16 1985, that (I/we) lost (saw the deceased) alive on 1/16/85 1985, and that in (my/our) opinion death occurred on the date and hour and from the causes stated above. (I/we) (did) (did not) view the body after death.  |  |   |  |   |                                     |   |                    |  |  |
| 22b. SIGNATURE<br>Charles B. Treasure MD   |  |   |  | DEGREE<br>MD ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>     |                                     |   |                    | 22c. DATE SIGNED<br>1/16/85  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>Charles B. Treasure   |  |   |  | 22e. ADDRESS<br>Francis Scott Key Med Ctr, Balt, MD   |                                     |   |                    |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br>Burial  |  | 23b. DATE<br>1/21/85  |  | 23c. NAME OF CEMETERY OR CREMATORY<br>Eastview Cem.   |                                     | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Baltimore MD                                      |                    |  |  |
| 24. FUNERAL DIRECTOR<br>George J. Gonca 4001 Ritchie Hgwy Balto Md   |  |   |  |   |                                     | 25a. DATE REC'D. BY REGISTRAR<br>JAN 21 1985  |                    | 25b. REGISTRAR'S SIGNATURE<br>[Signature]  |  |

RECEIVED

1967-1968

1967-1968

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1967-1968

1967-1968

1967-1968

1967-1968

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1967-1968



STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. FOR  
STATE  
REGISTRAR

|   |  |   |   |  |   |
|---|--|---|---|--|---|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>FIRST MIDDLE LAST<br>Edward Angelo Salvarola |  |   | 2a. DATE OF DEATH MONTH DAY YEAR<br>January 1 1985  |  | 2b. HOUR<br>8:30 A.M.   |
| 3. SEX<br>Male  | 4. RACE<br>White   | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>Oct. 17 1904  |   | 6. AGE (IN YEARS LAST BIRTHDAY)<br>80 YRS                            | IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS<br>HOURS MIN. |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>N.Y.                                   | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.A.   | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Baltimore City MD.           |   |
| 10. CITY OR TOWN OF DEATH<br>Baltimore  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>5742 Cedonia Ave. Apt. B. |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Salesman-Mgr. Furniture Co. |  | 12b. KIND OF BUSINESS OR INDUSTRY                               |
| 13a. STATE<br>Md.   | 13b. COUNTY  | 13c. CITY OR TOWN<br>Baltimore  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | 13e. STREET ADDRESS / ZIP CODE<br>5742 Cedonia Ave. 21206            |   |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>Michael Salvarola                         |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Theresa DiFlillipo   |   |  |   |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br>yes         |  | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br>Peacetime 218-10-1335  |   | 17. INFORMANT ADDRESS<br>same address<br>Olivia May Salvarola (wife) |   |

|  |  |   |
|--|--|---|
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a). <i>Congestive Heart Failure</i> |  | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH |
| DUE TO, OR AS A CONSEQUENCE OF<br>(b) _____  |  |   |
| DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____  |  |   |

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a.

|  |  |  |   |
|--|--|--|---|
| 19a. DATE OF OPERATION   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                       | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>  | 20b. IF YES, WERE FINDINGS USED<br>IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19             | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)   |   |
| 21d. INJURY OCCURRED<br>WHERE <input type="checkbox"/> NOT WHERE <input type="checkbox"/><br>AT WORK AT WORK   | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE  |   |
| 22a. I certify that (I) (this hospital) attended the deceased from<br>saw the deceased alive on 4-13-84, 1984, and that in (my) opinion death occurred on the date and hour and from the causes stated<br>above. (I) (we) (did not) view the body after death. |  |  |   |
| 22b. SIGNATURE<br><i>Dr. Anderson Renick</i>   |  | DEGREE<br>ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | 22c. DATE SIGNED<br>1/3/85  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>Dr. Anderson Renick   |  | 22e. ADDRESS<br>7600 Osler Drive, Suite 401  |   |

|   |                     |  |   |
|---|---------------------|--|---|
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br>Burial  | 23b. DATE<br>1/4/85 | 23c. NAME OF CEMETERY OR CREMATORY<br>Gardens of Faith | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Baltimore Md. |
| 24. FUNERAL DIRECTOR<br>NAME<br>Schimunek Funeral Home Inc.<br>3331 Brehms Lane, Balto. Md. 21213 |                     | 25a. DATE REC'D. BY REGISTRAR<br>JAN 4 1985            | 25b. REGISTRAR'S SIGNATURE<br><i>Dr. Anderson Renick</i>    |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial/transit permit. Then please remove carbonpapers, Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.



BOARD

NUMBER

Section 104 of the Act

FILE

2000

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|  |  |   |  |   |  |  |  |
|--|--|---|--|---|--|--|--|
| 1. FOR<br>STATE<br>REGISTRAR   |  | 1. DECEASED NAME<br>(TYPE OR PRINT)   |  | 2a. DATE OF DEATH   |  | 2b. HOUR   |  |
|  |  | LEAH SAMMEL   |  | JAN. 26, 1985   |  | 2:39P M  |  |
| 3. SEX   |  | 4. RACE   |  | 5. DATE OF BIRTH  |  | 6. AGE   |  |
| FEMALE   |  | WHITE   |  | DEC. 6, 1926  |  | 58 YRS   |  |
| 7a. BIRTHPLACE   |  | 7b. CITIZEN OF WHAT COUNTRY?  |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH   |  |
| MARYLAND   |  | USA   |  |   |  | BALTIMORE CITY MD.   |  |
| 10. CITY OR TOWN OF DEATH  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION                                       |  | 12a. USUAL OCCUPATION   |  | 12b. KIND OF BUSINESS OR INDUSTRY  |  |
| BALTIMORE  |  | SINAI HOSPITAL  |  | SECTY - WATER DEPT.   |  | BALTO. CITY  |  |
| 13a. STATE   |  | 13b. COUNTY   |  | 13c. CITY OR TOWN   |  | 13d. INSIDE CITY LIMITS?   |  |
| MARYLAND   |  | BALTIMORE   |  | OWINGS MILLS  |  | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                        |  |
| 14. FATHER'S NAME  |  | 15. MOTHER'S MAIDEN NAME  |  | 13e. STREET ADDRESS / ZIP CODE  |  | 13f. NOBILITY CT. (21117)  |  |
| HARRY KUSHNER  |  | BESSIE MALLOW   |  | 2A NOBILITY CT. (21117)   |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?   |  | 16b. SOCIAL SECURITY NO.  |  | 17. INFORMANT   |  | ADDRESS  |  |
| NO   |  | 213- 20-4199  |  | MRS. RUTH BLATT   |  | OWINGS MILLS, MD   |  |
| 18. CAUSE OF DEATH   |  | 19. OTHER SIGNIFICANT CONDITIONS  |  | 20a. AUTOPSY?   |  | 20b. IF YES, WERE FINDINGS USED  |  |
| PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) CONGESTIVE HEART FAILURE<br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) CORONARY ARTERY DISEASE<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) DIABETES. HYPERTENSION  |  | CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: a |  | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  | IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br>1 YEAR<br>5 YEARS  |  |   |  |   |  |  |  |
| 21a. DATE OF OPERATION   |  | 21b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  | 21c. HOW INJURY OCCURRED  |  | 21d. IF YES, WERE FINDINGS USED  |  |
|  |  |   |  | (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)   |  | IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21e. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21f. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19                                    |  | 21g. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21h. LOCATION<br>CITY OR TOWN COUNTY STATE   |  |
| 21i. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>   |  |   |  |   |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from<br>saw the deceased alive on JANUARY 3, 1985, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated<br>above, (I) (we) (did not) view the body after death. |  | 22b. SIGNATURE<br>Barnett Berman, MD  |  | 22c. DATE SIGNED<br>1/27/85   |  |  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)  |  | 22e. ADDRESS  |  | 22f. DATE REC'D. BY REGISTRAR   |  | 22g. REGISTRAR'S SIGNATURE   |  |
| BARNETT BERMAN   |  | 611 PARK AVE. BALTIMORE, MD. (21201)  |  | JAN 29 1985   |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL  |  | 23b. DATE   |  | 23c. NAME OF CEMETERY OR CREMATORY  |  | 23d. LOCATION  |  |
| BURIAL   |  | 1/27/85   |  | HAR ZION TIFERETH ISRAEL  |  | ROSEDALE, BALTO, MD.   |  |
| 24. FUNERAL DIRECTOR   |  | 24b. ADDRESS  |  | 24c. DATE REC'D. BY REGISTRAR   |  | 24d. REGISTRAR'S SIGNATURE   |  |
| SOL LEVINSON & BROS.   |  | 6010 REISTERSTOWN RD. BALTIMORE, MD. (21215)  |  | JAN 29 1985   |  |  |  |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 4 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified prior to burial, cremation, or removal.

*[Faint, illegible text, likely bleed-through from the reverse side of the page]*

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 24 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BPMH - 17  
(VR A15 ME (5))

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>MEDICAL EXAMINER'S CERTIFICATE OF DEATH   |  |   |  |   |  |   |  |  |                                   | REG. NO. 01498  |  |
|---|--|---|--|---|--|---|--|--|-----------------------------------|---|--|
| 1. DECEASED NAME (TYPE OR PRINT)<br>FIRST MIDDLE LAST<br>Vandalo Sample   |  |   |  |   |  | 2a. DATE KNOWN OF DEATH<br>MONTH DAY YEAR<br>1 22 19 85   |  |  | 2b. HOUR<br>AM PM<br>10PM         |   |  |
| 3. SEX<br>Male  |  | 4. RACE<br>Black  |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>Aug. 14, '39  |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br>45 YRS.  |  | 7. IF UNDER 24 HRS.<br>MONTHS DAYS HOURS MIN.                  |                                   | 7c. DATE PRONOUNCED DEAD<br>MONTH DAY YEAR<br>1 22 19 85                            |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Maryland   |  | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.A.  |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Baltimore City MD.                                      |  |  |                                   |   |  |
| 10. CITY OR TOWN OF DEATH<br>Baltimore  |  | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>1525 Riggs Avenue |  |   |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)                                   |  |  | 12b. KIND OF BUSINESS OR INDUSTRY |   |  |
| 13a. STATE<br>Maryland  |  | 13b. COUNTY<br>Baltimore  |  | 13c. CITY OR TOWN<br>Baltimore  |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 13e. STREET ADDRESS<br>1525 Riggs Avenue 21217                 |                                   |   |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>John Sample   |  |   |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Marie  |  |   |  |  |                                   |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO, OR UNKNOWN)   |  |   |  | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br>213-34-3199  |  | 17. INFORMANT<br>Felicia Toulson  |  | ADDRESS<br>722 Cumberland Street                               |                                   |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Smoke and soot inhalation</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost.<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____   |  |   |  |   |  |   |  |  |                                   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH  |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)  |  |   |  |   |  |   |  |  |                                   |   |  |
| 19a. DATE OF OPERATION  |  |   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?   |  |   |  |  |                                   | 20. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH  |  |   |  | 21b. TIME OF INJURY<br>HOUR MONTH DAY YEAR<br>9:30 M. 1 22 19 85  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)<br>House fire     |  |  |                                   |   |  |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>   |  |   |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)<br>home   |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE<br>1525 Riggs Ave, Baltimore MD.              |  |  |                                   |   |  |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural cause <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input checked="" type="checkbox"/> . |  |   |  |   |  |   |  |  |                                   |   |  |
| ACTUAL SIGNATURE<br>  |  |   |  | TITLE (SPECIFY)<br>M.D. Assistant   |  |   |  | DATE SIGNED<br>1/23/85   |                                   |   |  |
| EXAMINER'S NAME (TYPE OR PRINT)<br>Gregory R, Kauffman, M.D.  |  |   |  | ADDRESS<br>111 Penn St. Balto.MD.   |  |   |  |  |                                   |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br>Burial   |  | 23b. DATE<br>1/26/85  |  | 23c. NAME OF CEMETERY OR CREMATORY<br>King Memorial Park  |  |   |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Randallstown MD. |                                   |   |  |
| 24. FUNERAL DIRECTOR<br>NAME<br>Irvin Carroll   |  |   |  | ADDRESS<br>1712-14 W. North Ave.  |  |   |  | 25a. DATE REC'D. BY REGISTRAR<br>JAN 29 1985                   |                                   |   |  |

MEDICAL CERTIFICATION



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM FM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP

DHMH - 17  
(VR A15 ME (5))  
20M 4/82

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

1- FOR  
STATE  
REGISTRAR

|   |  |  |   |  |  |   |  |  |   |  |  |   |   |  |   |  |  |   |  |  |   |  |  |
|---|--|--|---|--|--|---|--|--|---|--|--|---|---|--|---|--|--|---|--|--|---|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)   |  |  | FIRST<br>Susan  |  |  | MIDDLE<br>C.  |  |  | LAST<br>Sams  |  |  | 2a. DATE KNOWN OF DEATH<br>ESTIMATED                                  |   |  | <input checked="" type="checkbox"/> MONTH DAY YEAR  |  |  | 2b. HOUR  |  |  |   |  |  |
| 3. SEX<br>Female  |  |  | 4. RACE<br>White  |  |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR  |  |  | 6. AGE (IN YEARS)<br>LAST BIRTHDAY  |  |  | IF UNDER 1 YR.<br>MONTHS DAYS   |   |  | IF UNDER 24 HRS.<br>HOURS MIN.  |  |  | 7c. DATE PRONOUNCED DEAD  |  |  | 7d. HOUR  |  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Maryland   |  |  | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.A.                                |  |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Baltimore City,   |  |  | 10. CITY OR TOWN OF DEATH<br>Baltimore                                |   |  | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>University Hospital |  |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Factory Worker |  |  | 12b. KIND OF BUSINESS OR INDUSTRY<br>Sons A. Schreter & |  |  |
| 13a. STATE<br>Maryland  |  |  | 13b. CITY OR TOWN<br>Baltimore  |  |  | 13c. CITY OR TOWN<br>Dundalk  |  |  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |  | 13e. STREET ADDRESS<br>7912 Charlesmont Rd. 21222                     |   |  | 14. FATHER'S NAME<br>FIRST MIDDLE LAST  |  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST                                   |  |  |   |  |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST  |  |  | Edward William Sams, Sr.  |  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST   |  |  | Carolyn J. Wiesand  |  |  | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO, OR UNKNOWN) |   |  | 16b. SOCIAL SECURITY NO.<br>214-56-3272   |  |  | 17. INFORMANT<br>Edward W. Sams, Sr.  |  |  | ADDRESS<br>Same as 13e                                  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Multiple injuries</u><br>8147<br>Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost:<br>(b) _____<br>(c) _____<br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH   |  |  |   |  |  |   |  |  |   |  |  |   |   |  |   |  |  |   |  |  |   |  |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).   |  |  |   |  |  |   |  |  |   |  |  |   |   |  |   |  |  |   |  |  |   |  |  |
| 19a. DATE OF OPERATION  |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?                     |  |  |   |  |  |   |  |  |   | 20. AUTOPSY?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |   |  |  |   |  |  |   |  |  |
| 21a. EXTERNAL CAUSE WAS<br>UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH   |  |  | 21b. TIME OF INJURY<br>HOUR XX MONTH DAY YEAR<br>11:05 AM 1 12 19 85  |  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)<br>Pedestrian struck by auto  |  |  |   |  |  |   |   |  |   |  |  |   |  |  |   |  |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>  |  |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)<br>street |  |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE<br>Old NorthPoint Rd Baltimore Balto.Co.MD.   |  |  |   |  |  |   |   |  |   |  |  |   |  |  |   |  |  |
| 22. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> . |  |  |   |  |  |   |  |  |   |  |  |   |   |  |   |  |  |   |  |  |   |  |  |
| ACTUAL SIGNATURE<br>Thomas D. Smith, M.D.   |  |  | TITLE (SPECIFY)<br>M.D. Acting Chief                                  |  |  |   |  |  |   |  |  |   | DATE SIGNED<br>1/15/85  |  |   |  |  |   |  |  |   |  |  |
| EXAMINER'S NAME<br>(TYPE OR PRINT)  |  |  | ADDRESS<br>111 Penn St. Balto.MD.                                     |  |  |   |  |  |   |  |  |   |   |  |   |  |  |   |  |  |   |  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)  |  |  | 23b. DATE<br>1/18/1985  |  |  | 23c. NAME OF CEMETERY OR CREMATORY<br>Gardens Of Faith  |  |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Baltimore Maryland                                |  |  |   |   |  |   |  |  |   |  |  |   |  |  |
| 24. FUNERAL DIRECTOR<br>NAME<br>7922 Wise Avenue  |  |  | ADDRESS<br>Dundalk, MD. 21222   |  |  | 25a. DATE REC'D. BY REGISTRAR<br>JAN 18 1985  |  |  | 25b. REGISTRAR'S SIGNATURE<br>[Signature]   |  |  |   |   |  |   |  |  |   |  |  |   |  |  |



DMC/DA M/S

HAJRA MOTILLO



STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8501500

FOR  
STATE  
REGISTRAR

REG. NO.

|   |  |  |   |   |  |  |  |   |  |
|---|--|--|---|---|--|--|--|---|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br><b>VALERIE LOU SASADA</b>  |  |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>1 18 85</b> |   |  | 2b. HOUR<br><b>345A</b>  |  |   |  |
| 3. SEX<br><b>FEMALE</b>   |  | 4. RACE<br><b>WHITE</b>  |   | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>NOV. 12 1925</b>   |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>59</b> YRS.  |  | 7. IF UNDER 1 YEAR<br>MONTHS DAYS<br><b>0 0</b>   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>TENN.</b>   |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>  |   | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore City</b> MD.  |  |   |  |
| 10. CITY OR TOWN OF DEATH<br><b>BALTIMORE</b>   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>MERCY HOSPITAL</b> |   |   |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>NONE</b>  |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>-</b>   |  |
| 13a. STATE<br><b>MD.</b>  |  | 13b. COUNTY<br><b>-</b>  |   | 13c. CITY OR TOWN<br><b>BALTIMORE</b>   |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>  |  | 13e. STREET ADDRESS<br><b>307 E. 31st St. 21218</b>   |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>UNKNOWN</b>  |  |  |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>UNKNOWN</b>   |  |  |  |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>NO</b>   |  | 16b. SOCIAL SECURITY NO.<br><b>216-14-3836</b>   |   | 17. INFORMANT<br>ADDRESS<br><b>15 FERNDAL AVE.</b>  |  | 17b. IF YES, WERE FINDINGS USED<br>IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>              |  | 17c. DATE SIGNED<br><b>1/18/85</b>  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>RESPIRATORY INSUFFICIENCY</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(b) <b>CARCINOMA OF THE LUNG</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____ |  |  |   |   |  |  |  | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH   |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: _____  |  |  |   |   |  |  |  |   |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |   |   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>  |  | 20b. IF YES, WERE FINDINGS USED<br>IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>  |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |  |  |  |   |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |  |  |   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>1/13</b> 19 <b>85</b> , to <b>1/18</b> 19 <b>85</b> , that (I) (we) lost<br>saw the deceased alive on _____ 19 _____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated<br>above, (I) (we) (did) (did not) view the body after death.                                 |  |  |   |   |  |  |  |   |  |
| 22b. SIGNATURE<br><b>Michael J. Fisher MD</b>   |  |  |   | DEGREE<br><b>MD</b>   |  | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> |  | 22c. DATE SIGNED<br><b>1/18/85</b>  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>MICHAEL J FISHER MD</b>   |  |  |   | 22e. ADDRESS<br><b>MERCY HOSPITAL Bldg MD 21202</b>   |  |  |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>BURIAL</b>   |  | 23b. DATE<br><b>1/21/85</b>  |   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>PARKWOOD</b>   |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>BALTIMORE MD.</b>   |  |   |  |
| 24. FUNERAL DIRECTOR<br>NAME ADDRESS<br><b>SCHIMUNEK FUNERAL HOME INC.<br/>3331 Brehms Lane, Balto. Md. 21213</b>   |  |  |   | 25a. DATE REC'D. BY REGISTRAR<br><b>JAN 18 1985</b>   |  | 25b. REGISTRAR'S SIGNATURE<br><b>[Signature]</b>   |  |   |  |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 1 and 2 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

SCHEIDT & BOWNE, NEW YORK



50% COTTON

THE KIMM

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

85 01501

REG. NO.

|   |  |  |  |  |  |  |  |   |  |   |  |  |  |  |
|---|--|--|--|--|--|--|--|---|--|---|--|--|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>Ethel</b>  |  |  | FIRST MIDDLE LAST <b>SATOSKY</b>   |  |  | 2a. DATE OF DEATH MONTH DAY YEAR <b>1/1/85</b>   |  |   | 2b. HOUR <b>225 P</b><br>M   |   |  |  |  |  |
| 3. SEX <b>FEMALE</b>  |  |  | 4. RACE <b>WHITE</b>   |  |  | 5. DATE OF BIRTH MONTH DAY YEAR <b>03 03 11</b>  |  |   | 6. AGE (IN YEARS (LAST BIRTHDAY)) <b>73</b><br>YRS. MONTHS DAYS HOURS MIN.     |   |  |  |  |  |
| 7. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>MARYLAND</b>  |  |  | 7b. CITIZEN OF WHAT COUNTRY? <b>US A</b>   |  |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  |   | 9. BALTIMORE CITY OR COUNTY OF DEATH <b>Baltimore CITY</b> MD.                 |   |  |  |  |  |
| 10. CITY OR TOWN OF DEATH <b>Baltimore</b>  |  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>SINAI HOSPITAL</b> |  |  |  |  |   | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>HOUSEWIFE</b> |   |  | 12b. KIND OF BUSINESS OR INDUSTRY <b>AT HOME</b> |  |  |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) <b>Md BALTO</b>  |  |  |  |  |  | 13b. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>   |  |   | 13c. STREET ADDRESS <b>APT. 204 #21215 4800 yellowstone Rd</b>                 |   |  |  |  |  |
| 14. FATHER'S NAME FIRST MIDDLE LAST <b>SAMUEL DAVIDSON</b>  |  |  |  |  |  | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>J. NEWMAN</b>  |  |   |  |   |  |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>NO</b>   |  |  |  |  |  | 16b. 218-40-428 21314403 INFORMANT <b>SANDER SATOSKY</b><br>7600 LORRY LANE BALTO., MD 21208   |  |   |  |   |  |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Cardiac Arrest</b><br>DUE TO, OR AS A CONSEQUENCE OF (b) <b>Arteriosclerosis</b><br>DUE TO, OR AS A CONSEQUENCE OF (c) <b>old loss</b>  |  |  |  |  |  |  |  |   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH  |  |  |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a) <b>Questionable old myocardial infarction</b>  |  |  |  |  |  |  |  |   |  |   |  |  |  |  |
| 19a. DATE OF OPERATION  |  |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                   |  |  |  | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> |  |  |  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |  |  |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>12/21 1984</b>     |  |  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)    |  |   |  |  |  |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>  |  |  |  | 21e. PLACE OF INJURY (AT HOME STREET, FACTORY, OFFICE, FARM, ETC.) |  |  |  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE                                    |  |   |  |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>12/21 1984</b> to <b>1/1 1985</b> , that (I) (we) lost saw the deceased alive on <b>1/1/85</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |  |  |  |  |  |  |  |   |  |   |  |  |  |  |
| 22b. SIGNATURE <b>Francis Caban</b> MD 9137   |  |  |  |  |  | 22c. DATE SIGNED <b>1/1/85</b>   |  |   |  |   |  |  |  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>FRANCIS CABAN</b>  |  |  |  |  |  | 22e. ADDRESS <b>SINAI HOSPITAL</b>   |  |   |  |   |  |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>BURIAL</b>   |  |  |  | 23b. DATE <b>JAN. 2, 1985</b>                                      |  | 23c. NAME OF CEMETERY OR CREMATORY <b>BETH ISAAC ADATH ISRAEL</b>  |  |   |  | 23d. LOCATION CITY OR TOWN COUNTY MARYLAND  |  |  |  |  |
| 24. FUNERAL DIRECTOR <b>SOL LEVINSON &amp; BROS., INC.</b><br>NAME ADDRESS <b>6010 REISTERSTOWN RD. BALTO., MD 21215</b>  |  |  |  |  |  | 25a. DATE REC'D BY REGISTRAR <b>JAN 9 1985</b>   |  | 25b. REGISTRAR'S SIGNATURE <b>Jana Davidson-Randall</b>                           |  |   |  |  |  |  |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be filed within 72 hours after death. Page 3 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

3

10/10

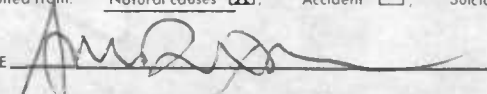
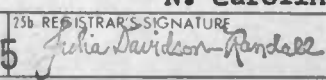
21-10-515

YLMND

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

FOR  
STATE  
REGISTRAR

|   |  |   |  |   |  |  |  |   |  |   |  |
|---|--|---|--|---|--|--|--|---|--|---|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)   |  | FIRST<br><b>BEN</b>   |  | MIDDLE  |  | LAST<br><b>SAULS</b>   |  | 2a. DATE KNOWN OF DEATH<br>ESTIMATED <input checked="" type="checkbox"/> MONTH DAY YEAR                             |  | 2b. HOUR  |  |
| 3. SEX<br><b>Male</b>   |  | 4. RACE<br><b>Black</b>   |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>10 01 1906</b>   |  | 6. AGE (IN YEARS)<br>(LAST BIRTHDAY)<br><b>78</b> YRS.                                   |  | IF UNDER 1 YR.<br>MONTHS DAYS   |  | IF UNDER 24 HRS.<br>HOURS MIN   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>N. Carolina</b>   |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U. S. A.</b>   |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore City</b>                            |  | 2c. DATE PRONOUNCED DEAD<br>MONTH DAY YEAR<br><b>1 10 19 85</b>   |  | 2d. HOUR<br><b>2:51 PM</b>  |  |
| 10. CITY OR TOWN OF DEATH<br><b>Baltimore</b>   |  | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>St. Agnes Hospital</b> |  |   |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Machine Operator</b> |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>Railroad</b>  |  | MD. <b>B &amp; O</b>  |  |
| 13a. STATE<br><b>Maryland</b>   |  |   |  | 13b. COUNTY   |  | 13c. CITY OR TOWN<br><b>Baltimore</b>  |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                     |  | 13e. STREET ADDRESS<br><b>3424 Caton Avenue<br/>Baltimore, Maryland 21229</b> |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Jerden</b>   |  |   |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Mary Ford</b>   |  |  |  |   |  |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO, OR UNKNOWN)<br><b>No</b>  |  |   |  | 16b. SOCIAL SECURITY NO.<br><b>244-12-2834</b>  |  | 17. INFORMANT<br><b>Jeanette Sauls</b>   |  |   |  | 3424 Caton Avenue<br>Baltimore, Maryland 21229                                |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Arteriosclerotic cardiovascular disease</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____   |  |   |  |   |  |  |  |   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH                                  |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)  |  |   |  |   |  |  |  |   |  |   |  |
| 19a. DATE OF OPERATION  |  |   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?   |  |  |  | 20. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                                 |  |   |  |
| 21a. EXTERNAL CAUSE WAS<br>UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH  |  |   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)            |  |   |  |   |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>   |  |   |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)   |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE  |  |   |  |   |  |
| 22a. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: <b>Natural causes</b> <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> . |  |   |  |   |  |  |  |   |  |   |  |
| ACTUAL SIGNATURE   |  |   |  |   |  | TITLE (SPECIFY)<br>M.D. <b>Assistant</b> MEDICAL EXAMINER                                |  | DATE SIGNED <b>1-11-85</b>  |  |   |  |
| EXAMINER'S NAME (TYPE OR PRINT) <b>Ann M. Dixon, M.D.</b>   |  |   |  |   |  | ADDRESS <b>111 Penn St., Balto., Md. 21201</b>   |  |   |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>Burial</b>  |  | 23b. DATE<br><b>1/19/85</b>   |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Rest Haven Cemetery</b>  |  |  |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Wilson, N. Carolina</b>  |  |   |  |
| 24. FUNERAL DIRECTOR<br><b>Nutter &amp; Sons 2501 Gwynns Falls Parkway<br/>Funeral Home Inc. Baltimore, Maryland 21216</b>  |  |   |  |   |  | 25a. DATE REC'D. BY REGISTRAR<br><b>JAN 17 1985</b>                                      |  | 25b. REGISTRAR'S SIGNATURE<br> |  |   |  |

MEDICAL CERTIFICATION

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

Male Black 10 01 1905 78

U. S. A. N. Carolina

Machine Operator Baltimore  
3636 Canton Avenue  
Baltimore, Maryland 21229

Baltimore

Maryland

3636 Canton Avenue  
Baltimore, Maryland 21229

3636

3636

3636



RECEIVED  
MAY 14 1965  
FBI - BALTIMORE

General Home Inc. Baltimore, Maryland 21216  
Letter & Sons 2501 Gwynne Falls Parkway  
Baltimore, Maryland 21216  
Wilson, N. Carolina



STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 5 0 1 5 0 3

1- FOR  
STATE  
REGISTRAR

REG. NO.

|   |  |   |   |   |   |  |   |  |  |  |
|---|--|---|---|---|---|--|---|--|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br><b>IGNAS SAULYNAS MD</b>   |  |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>JANUARY 28, 1985</b>          |   |   | 2b. HOUR<br>MIN.<br><b>01:20am</b>   |   |  |  |  |
| 3. SEX<br><b>Male</b>   |  | 4. RACE<br><b>White</b>   |   | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>Jan. 31, 1918</b>  |   | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>66</b> YRS.                                    |   | IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 72 HRS.<br>HOURS MIN.   |  |  |
| 7a. BIRTHPLACE<br>(STATE OR FOREIGN COUNTRY)<br><b>Lithuania</b>  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>   |   | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>       |   | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>BALTIMORE CITY</b> MD                     |   |  |  |  |
| 10. CITY OR TOWN OF DEATH<br><b>BALTIMORE</b>   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH PLACE, GIVE STREET ADDRESS)<br><b>JOHNS HOPKINS HOSPITAL</b> |   |   |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Physician</b> |   | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>Medical</b>  |  |  |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE<br><b>Maryland</b>   |  |   | 13b. COUNTY<br><b>Baltimore</b>   |   | 13c. CITY OR TOWN<br><b>Catonsville</b> |  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  | 13e. STREET ADDRESS / ZIP CODE<br><b>1704 Beechwood Avenue 21228</b> |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Antanas Saulynas</b>   |  |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Agota Saudziute</b> |   |   |  |   |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>No</b>   |  | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br><b>215-40-0296</b>   |   | 17. INFORMANT<br>ADDRESS<br><b>Valerija Saulynas Same as # 13</b>   |   |  |   |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Cordis pulmonary Arrest</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <b>Pneumonia &amp; Liver failure</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <b>Acute myelogenous leukemia</b><br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>1 min</b><br><b>6 days</b> |  |   |   |   |   |  |   |  |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)<br><b>NONE</b>   |  |   |   |   |   |  |   |  |  |  |
| 19a. DATE OF OPERATION<br><b>N/A</b>  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED<br><b>N/A</b>  |   |   |   | 20a. AUTOPSY?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |   | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>N/A</b>   |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)<br><b>N/A</b>  |   |  |   |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> <b>N/A</b>  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)<br><b>N/A</b>  |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE<br><b>N/A</b>   |   |  |   |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>1/22</b> 19 <b>85</b> to <b>1/28</b> 19 <b>85</b> , that (I) (we) lost saw the deceased alive on <b>1/28/85</b> 19 <b>85</b> and that in my (our) opinion death occurred on the date and hour and from the causes stated above (I) (we) (did) (did not) view the body after death.  |  |   |   |   |   |  |   |  |  |  |
| 22b. SIGNATURE<br><b>Stuart Katz</b>  |  |   |   | DEGREE<br><b>MD</b><br>ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> |   |  |   | 22c. DATE SIGNED<br><b>1/28/85</b>   |  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>Stuart Katz</b>   |  |   |   | 22e. ADDRESS<br><b>4940 EASTERN AVE BALTO 21224</b>   |   |  |   |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>Cremation</b>  |  | 23b. DATE<br><b>1/31/85</b>   |   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Loudon Park Crematory</b>  |   | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Baltimore Md.</b>                   |   |  |  |  |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>Leroy M. &amp; Russell C. Witzke Funeral Homes P.A.</b><br>ADDRESS<br><b>1630 Edmondson Avenue, Catonsville, Md. 21228</b>   |  |   |   | 25a. DATE REC'D BY REGISTRAR<br><b>JAN 29 1985</b>  |   | 25b. REGISTRAR'S SIGNATURE<br><b>John Davidson-Randall</b>                           |   |  |  |  |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 1 and 2 should be detached for use as the transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked off item 18 shows any injury, or other traumatic event, the medical examiner must be notified of cause.

BP



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STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 5 0 1 5 0 4

FOR  
1- STATE  
REGISTRAR

REG. NO.

|  |  |   |  |   |  |
|--|--|---|--|---|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br><b>JOSEPH CHARLES SAVERINO</b>  |  |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>1 5 85</b>   |   | 2b. HOUR<br><b>8:20PM</b>  |
| 3. SEX<br><b>MALE</b>  | 4. RACE<br><b>WHITE</b>  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>09 25 12</b>   |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>72</b> YRS.                 | 7. IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS<br>HOURS MIN. |
| 8a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>MARYLAND</b>   | 8b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>BALTIMORE CITY</b> MD. |  |
| 10. CITY OR TOWN OF DEATH<br><b>BALTIMORE</b>  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>ST. AGNES HOSPITAL</b> |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>PRODUCE MANAGER</b>                                 |   | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>FOOD CHAIN</b>             |
| 13a. USUAL RESIDENCE (IF HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE<br><b>MARYLAND</b>  |  | 13b. CITY OR TOWN<br><b>BALTIMORE</b>   | 13c. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                            | 13e. STREET ADDRESS / ZIP CODE<br><b>417 WHEATON PLACE, 21228</b> |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>JOSEPH C. SAVERINO</b>  |  |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>CATHERINE MATARANO</b>   |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>NO</b>  | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br><b>100-03-8879</b>  | 17. INFORMANT ADDRESS<br><b>DONA SAVERINO 756 S. WOODINGTON ROAD</b>  |  |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Cardio-pulmonary arrest</b>  |  |   |  |   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>20 min</b>      |
| DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(b) <b>Aspiration</b>  |  |   |  |   | <b>20 min</b>  |
| DUE TO, OR AS A CONSEQUENCE OF<br>(c) <b>Stroke</b>  |  |   |  |   | <b>1 month</b>   |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: (a)<br><b>atherosclerotic Cardiovascular Disease</b>  |  |   |  |   |  |
| 19a. DATE OF OPERATION<br><b>12/4/84</b>   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED<br><b>(2) Carotid Stenosis</b>  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |   |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)  |  |   |  |
| 21d. INJURY OCCURRED<br>WHITE <input type="checkbox"/> NOT WHITE <input type="checkbox"/><br>AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>   | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>1/13</b> 19 <b>85</b> , to <b>1/5</b> 19 <b>85</b> , that (I) (we) last saw the deceased alive on <b>1/5</b> 19 <b>85</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did not) view the body after death. |  |   |  |   |  |
| 22b. SIGNATURE<br><b>William C. Doodley MD</b>   |  | DEGREE<br><b>MD</b>   |  | 22c. DATE SIGNED<br><b>1/5/84</b>                                 |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>DR. WILLIAM DOODLEY</b>  |  | 22e. ADDRESS<br><b>St Agnes Hospital</b>  |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>BURIAL</b>  | 23b. DATE<br><b>01-09-85</b>   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>MEADOWRIDGE MEM. PK.</b>   | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>ELKRIDGE HOWARD MARYLAND</b>  |   |  |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>HUBBARD FUNERAL HOME, INC.</b>  |  | 24b. ADDRESS<br><b>4107 WILKENS AVE.</b>  | 25a. DATE REC'D. BY REGISTRAR<br><b>JAN 7 1985</b>   | 25b. REGISTRAR'S SIGNATURE<br><b>Juha Davidson-Randall</b>        |  |

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MEDICAL CERTIFICATION

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BP.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked at item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM. 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>MEDICAL EXAMINER'S CERTIFICATE OF DEATH  |         |  |  |   |  |   |  |   |  |                          |  | REG. NO.  |
|--|---------|--|--|---|--|---|--|---|--|--------------------------|--|---|
| 1. DECEASED NAME<br>(TYPE OR PRINT)  |         | FIRST  |  | MIDDLE  |  | LAST  |  | 2a. DATE KNOWN OF DEATH ESTIMATED   |  |                          |  | 2b. HOUR  |
| Frank Campbell Saxton  |         |  |  |   |  |   |  | <input checked="" type="checkbox"/> MONTH <input type="checkbox"/> DAY <input type="checkbox"/> YEAR<br>1 15 1985 |  |                          |  | <input type="checkbox"/> M<br>11:36 a M                             |
| 3. SEX   | 4. RACE | 5. DATE OF BIRTH   |  | 6. AGE (IN YEARS LAST BIRTHDAY)   |  | IF UNDER 1 YR.  |  | IF UNDER 24 HRS.  |  | 7c. DATE PRONOUNCED DEAD |  | 2d. HOUR  |
| Male   | White   | Feb. 5, 1915   |  | 69 YRS.   |  |   |  |   |  | 1 15 1985                |  | 11:36 a M   |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)  |         | 7b. CITIZEN OF WHAT COUNTRY?   |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH                                |  |   |  |                          |  |   |
| Pennsylvania   |         | U.S.A.   |  | WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>                    |  | Baltimore City, MD  |  |   |  |                          |  |   |
| 10. CITY OR TOWN OF DEATH  |         | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) |  |   |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)       |  | 12b. KIND OF BUSINESS OR INDUSTRY   |  |                          |  |   |
| Baltimore  |         | Francis Scott Key Medical Center   |  |   |  | Conductor   |  | Railroad  |  |                          |  |   |
| 13a. STATE   |         | 13b. COUNTY  |  | 13c. CITY OR TOWN   |  | 13d. INSIDE CITY LIMITS?  |  | 13e. STREET ADDRESS   |  |                          |  |   |
| Maryland   |         |  |  | Baltimore   |  | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 5030 E. Eager St. 21205   |  |                          |  |   |
| 14. FATHER'S NAME  |         | 15. MOTHER'S MAIDEN NAME   |  | 16a. SOCIAL SECURITY NO.  |  | 17. INFORMANT   |  | 17. ADDRESS   |  |                          |  |   |
| Thomas A. Saxton   |         | Ella B. Fletcher   |  | 189-09-9181   |  | Thalma L. Saxton  |  | 5030 E. Eager St. 21205   |  |                          |  |   |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO, OR UNKNOWN)  |         | 16b. SOCIAL SECURITY NO.   |  | 17. INFORMANT   |  | 17. ADDRESS   |  | 17. ADDRESS   |  |                          |  |   |
| No   |         | 189-09-9181  |  | Thalma L. Saxton  |  | 5030 E. Eager St.   |  |   |  |                          |  |   |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1 DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Hypertensive cardiovascular disease</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last:<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____                                  |         |  |  |   |  |   |  |   |  |                          |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH                        |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).  |         |  |  |   |  |   |  |   |  |                          |  |   |
| 19a. DATE OF OPERATION   |         | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?  |  |   |  |   |  |   |  |                          |  | 20. AUTOPSY?  |
|  |         |  |  |   |  |   |  |   |  |                          |  | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH  |         | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)         |  |   |  |   |  |                          |  |   |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>   |         | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)  |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                     |  |   |  |   |  |                          |  |   |
| 22a. I certify that I took charge of the remains described above, held in death resulted from <input checked="" type="checkbox"/> Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .<br>TITLE (SPECIFY) M.D. Acting Chief MEDICAL EXAMINER<br>DATE SIGNED 1/15/85 |         |  |  |   |  |   |  |   |  |                          |  |   |
| ACTUAL SIGNATURE   |         | EXAMINER'S NAME (TYPE OR PRINT) Thomas D. Smith, M.D. ADDRESS 111 Penn St. Balto. MD.                      |  |   |  |   |  |   |  |                          |  |   |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)  |         | 23b. DATE  |  | 23c. NAME OF CEMETERY OR CREMATORY  |  | 23d. LOCATION CITY OR TOWN  |  | COUNTY  |  | STATE                    |  |   |
| Burial   |         | Jan. 18, 1985  |  | Meadowridge Mem. Park   |  | Elkridge,   |  | Howard,   |  | Rd.                      |  |   |
| 24. NAME OF FUNERAL HOME   |         | 24. ADDRESS  |  | 25a. DATE REC'D. BY REGISTRAR   |  | 25b. REGISTRAR'S SIGNATURE  |  |   |  |                          |  |   |
| ROBERT O. ALTENBURG FUNERAL HOME, INC.   |         | 6009 Harford Rd., Balto., Md. 21214  |  | JAN 17 1985   |  | Thalma L. Saxton  |  |   |  |                          |  |   |

43811 NOTED NOD

WV 1111



STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. FOR  
STATE  
REGISTRAR

|  |  |  |   |  |                                  |   |  |
|--|--|--|---|--|----------------------------------|---|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>FIRST MIDDLE LAST<br><b>SARAH L. SCHAAF</b>   |  |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>JAN. 1 1985</b> |  | 2b. HOUR<br>MIN.<br><b>755 A</b> |   |  |
| 3. SEX<br><b>Female</b>  |  | 4. RACE<br><b>CAUCASIAN</b>  |   | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>MARCH 14 1906</b>   |                                  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>78</b> YRS.   |  |
| 7a. BIRTHPLACE<br>(STATE OR FOREIGN COUNTRY)<br><b>Maryland</b>  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA.</b>  |   | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>  |                                  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>BALTO. CITY</b> MD.  |  |
| 10. CITY OR TOWN OF DEATH<br><b>Baltimore</b>  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Francis Scott Key M.C.</b>  |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Retired</b>   |                                  | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>Nat. Car Corp.</b>  |  |
| 13a. STATE<br><b>MD</b>  |  | 13b. COUNTY<br><b>Balto.</b>   |   | 13c. CITY OR TOWN<br><b>Baltimore</b>  |                                  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>HAMILTON</b>  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>ETTA COX</b>   |   | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)<br><b>NO</b>  |                                  | 16b. SOCIAL SECURITY NO.<br><b>217-36-9177</b>  |  |
| 17. INFORMANT<br>NAME ADDRESS<br><b>Mrs. Helen C. Kolg 26 Windjammer Ct. 21221</b>   |  | 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>CARDIORESPIRATORY ARREST</b><br>DUE TO, OR AS A CONSEQUENCE OF (b) <b>ELECTROLYTE ABNORMALITIES</b><br>DUE TO, OR AS A CONSEQUENCE OF (c) <b>ACUTE RENAL FAILURE</b> |   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH   |                                  | PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: ( )            |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>  |                                  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>                      |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER) |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19   |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)   |                                  | 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK              |  |
| 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE  |   | 21g. I certify that (I) (this hospital) attended the deceased from 1.1.85 to 1.1.85, that (I) (we) lost<br>saw the deceased alive on 1.1.85, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated<br>above, (I) (we) (did) (did not) view the body after death. |                                  | 22a. SIGNATURE<br><b>Gutheil</b>  |  |
| 22b. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>GUTHEIL</b>  |  | 22c. ADDRESS<br><b>FSK MC</b>  |   | 22d. DATE SIGNED<br><b>1.1.85</b>  |                                  | 22e. ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>Burial</b>  |  | 23b. DATE<br><b>1/4/1985</b>   |   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Oxklawn Cem.</b>  |                                  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>BALTO. MD</b>  |  |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>Joseph N. ZANNINO JR.</b>   |  | 25a. DATE REC'D. BY REGISTRAR<br><b>JAN 2 1985</b>   |   | 25b. REGISTRAR'S SIGNATURE<br><b>Julia Davidson-Randall</b>  |                                  | 25c. ADDRESS<br><b>363 South 21224</b>  |  |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be retained by the funeral director with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner should be notified at once.

*[Faint, mostly illegible handwritten text, possibly bleed-through from the reverse side of the page. Some words like "Mr. [illegible]" and "Dear [illegible]" are faintly visible.]*





TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL. TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201. PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP  
DHMH - 17  
(VR A15 ME (5))

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>MEDICAL EXAMINER'S CERTIFICATE OF DEATH  |  |                         |  |  |  |   |  |   |                           | REG. NO.  |  |
|--|--|-------------------------|--|--|--|---|--|---|---------------------------|---|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>HELEN E. (SHAIED) SCHAIED</b>   |  |                         |  |  |  |   |  |   |                           | 2a. DATE KNOWN OF DEATH<br>ESTIMATED <input checked="" type="checkbox"/> <b>1-6-85</b> 19 |  |
| 3. SEX<br><b>Female</b>  |  | 4. RACE<br><b>Black</b> |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR <b>4 11 21</b>  |  | 6. AGE (IN YEARS)<br>LAST BIRTHDAY <b>63 YRS.</b>                             |  | IF UNDER 1 YR.<br>MONTHS DAYS   |                           | IF UNDER 24 HRS.<br>HOURS MIN   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Maryland</b>   |  |                         |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>  |  |   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |                           | 2c. DATE PRONOUNCED DEAD<br><b>1-6-85</b> 19 <b>8:10P</b> AM                              |  |
| 10. CITY OR TOWN OF DEATH<br><b>Baltimore</b>  |  |                         |  | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>808 Bridgeview Road</b> |  |   |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)   |                           | 12b. KIND OF BUSINESS OR INDUSTRY   |  |
| 13a. STATE<br><b>Maryland</b>  |  |                         |  | 13b. COUNTY  |  | 13c. CITY OR TOWN<br><b>Baltimore</b>   |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>   |                           | 13e. STREET ADDRESS<br><b>808 Bridgeview Rd. 21225</b>                                    |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>William Schaied</b>   |  |                         |  |  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Emma Jones</b>            |  |   |                           |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO, OR UNKNOWN)<br><b>NO</b>   |  |                         |  | 16b. SOCIAL SECURITY NO.<br><b>212-14-8287</b>   |  | 17. INFORMANT ADDRESS<br><b>Rosetta D. Carter 5 Sugarloaf Ct. Apt. 201</b>    |  |   |                           |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Arteriosclerotic cardiovascular disease</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost:<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____<br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH                  |  |                         |  |  |  |   |  |   |                           |   |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)   |  |                         |  |  |  |   |  |   |                           |   |  |
| 19a. DATE OF OPERATION   |  |                         |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?  |  |   |  |   |                           | 20. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>       |  |
| 21a. EXTERNAL CAUSE WAS<br>UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH   |  |                         |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) |  |   |                           |   |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  |  |                         |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)  |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                             |  |   |                           |   |  |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> . |  |                         |  |  |  |   |  |   |                           |   |  |
| ACTUAL SIGNATURE <i>Margaret A. Korell</i>   |  |                         |  |  |  | TITLE (SPECIFY)<br>M.D. <b>Assistant</b> MEDICAL EXAMINER                     |  |   | DATE SIGNED <b>1-7-85</b> |   |  |
| EXAMINER'S NAME (TYPE OR PRINT) <b>Margarita A. Korell, M.D.</b>   |  |                         |  |  |  | ADDRESS <b>111 Penn Street</b>  |  |   |                           |   |  |
| 23a. BURIAL, CREMATION, REMOVAL<br><b>BURIAL</b>   |  |                         |  | 23b. DATE<br><b>1/10/85</b>  |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Md. National Mem Pk. Laurel,</b>     |  |   |                           | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE <b>Md.</b>                                     |  |
| 24. FUNERAL DIRECTOR<br>NAME ADDRESS<br><b>Wm C March F/H Inc. 1101 E North Avenue</b>   |  |                         |  |  |  | 25a. DATE REC'D. BY REGISTRAR<br><b>JAN 8 1985</b>                            |  | 25b. REGISTRAR'S SIGNATURE<br><i>Davidson-Randall</i>   |                           |   |  |



Film G603 item 14, 15

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

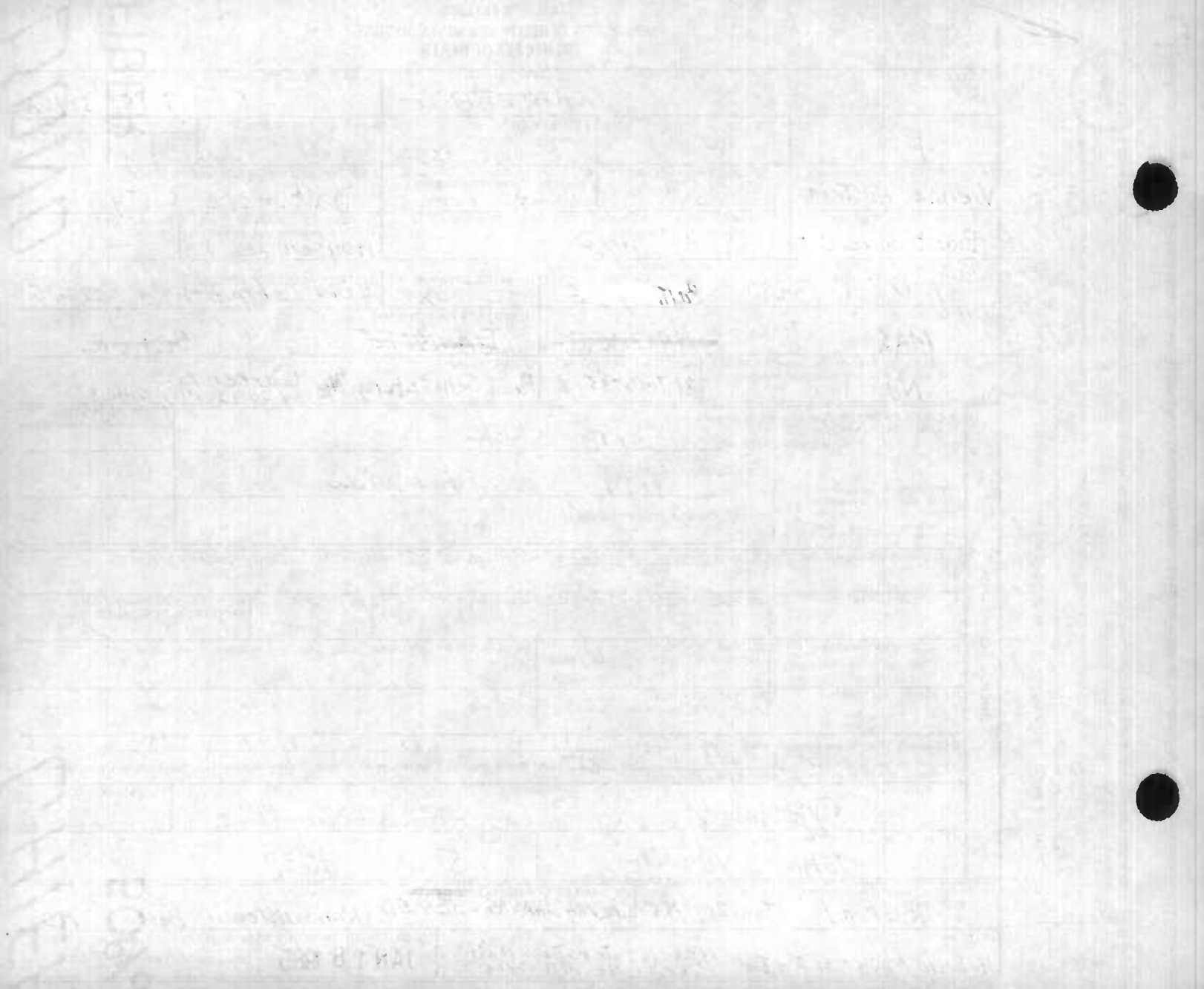
REG. NO.

|   |  |  |  |  |  |  |  |   |  |
|---|--|--|--|--|--|--|--|---|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>CELIA</b>  |  | FIRST <b>SCHATZBERG</b>  |  | LAST   |  | 2a. DATE OF DEATH MONTH DAY YEAR <b>1 17 85</b>                        |  | 2b. HOUR <b>5:15 PM</b>   |  |
| 3. SEX <b>F</b>   |  | 4. RACE <b>W</b>   |  | 5. DATE OF BIRTH MONTH DAY YEAR <b>5 15 1895</b>   |  | 6. AGE (IN YEARS LAST BIRTHDAY) <b>89</b>                              |  | 7. UNDER 1 YEAR MONTHS DAYS   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Vienna Austria</b>   |  | 7b. CITIZEN OF WHAT COUNTRY? <b>US</b>   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH <b>Baltimore City</b>             |  | MD.   |  |
| 10. CITY OR TOWN OF DEATH <b>Baltimore City</b>   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>SINAI HOSP</b> |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Housewife</b>   |  | 12b. KIND OF BUSINESS OR INDUSTRY <b>-</b>                             |  |   |  |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) STATE <b>MD</b> COUNTY <b>PRINCE GEORGES</b>   |  | 13b. CITY OR TOWN <b>PIKESVILLE</b>  |  | 13c. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  | 13d. STREET ADDRESS / ZIP CODE <b>4244 Labyrinth Rd 21215</b>          |  |   |  |
| 14. FATHER'S NAME FIRST <b>MAX</b> MIDDLE <b>Schor</b> LAST <b>SCHATZBERG</b>   |  | 15. MOTHER'S MAIDEN NAME FIRST <b>JEANETTE</b> MIDDLE <b>Schor</b> LAST <b>SCHATZBERG</b>                                |  | 16. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>NO</b>   |  | 16b. SOCIAL SECURITY NO. <b>217-16-8518</b>                            |  | 17. INFORMANT <b>Warren Dr. Hanapolis, MD 21403</b>   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Septic shock</b>   |  | DUE TO, OR AS A CONSEQUENCE OF (b) <b>UTI, debridement</b>   |  | DUE TO, OR AS A CONSEQUENCE OF (c) <b>-</b>  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH                           |  |   |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)  |  |  |  |  |  |  |  |   |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  |  |  | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>11 17 85</b>   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)  |  |  |  |   |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK  |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE   |  |  |  |   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>11/17</b> 19 <b>85</b> , to <b>1/17</b> 19 <b>85</b> , that (I) (we) last saw the deceased alive on <b>1/17</b> 19 <b>85</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |  |  |  |  |  |  |  |   |  |
| 22b. SIGNATURE <b>John Young</b>  |  | DEGREE   |  | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>                          |  | 22c. DATE SIGNED   |  |   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>JOHN YOUNG</b>   |  | 22e. ADDRESS <b>SINAI HOSP</b>   |  |  |  |  |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>   |  | 23b. DATE <b>Jan. 20, 1985</b>   |  | 23c. NAME OF CEMETERY OR CREMATOR <b>Cherry Hill Cemetery</b>  |  | 23d. LOCATION CITY OR TOWN COUNTY STATE <b>Randallstown Balto MD</b>   |  |   |  |
| 24. FUNERAL DIRECTOR NAME <b>Hebrew Memorial F.H. Inc.</b> ADDRESS <b>1100 Reisterstown Rd Pikesville, MD 21208</b>   |  | 25a. DATE REC'D BY REGISTRAR <b>JAN 18 1985</b>  |  | 25b. REGISTRAR'S SIGNATURE <b>John Davidson-Randall</b>  |  |  |  |   |  |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 3 and 4 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked "I", show any injury, the medical examiner will be notified at once.



STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

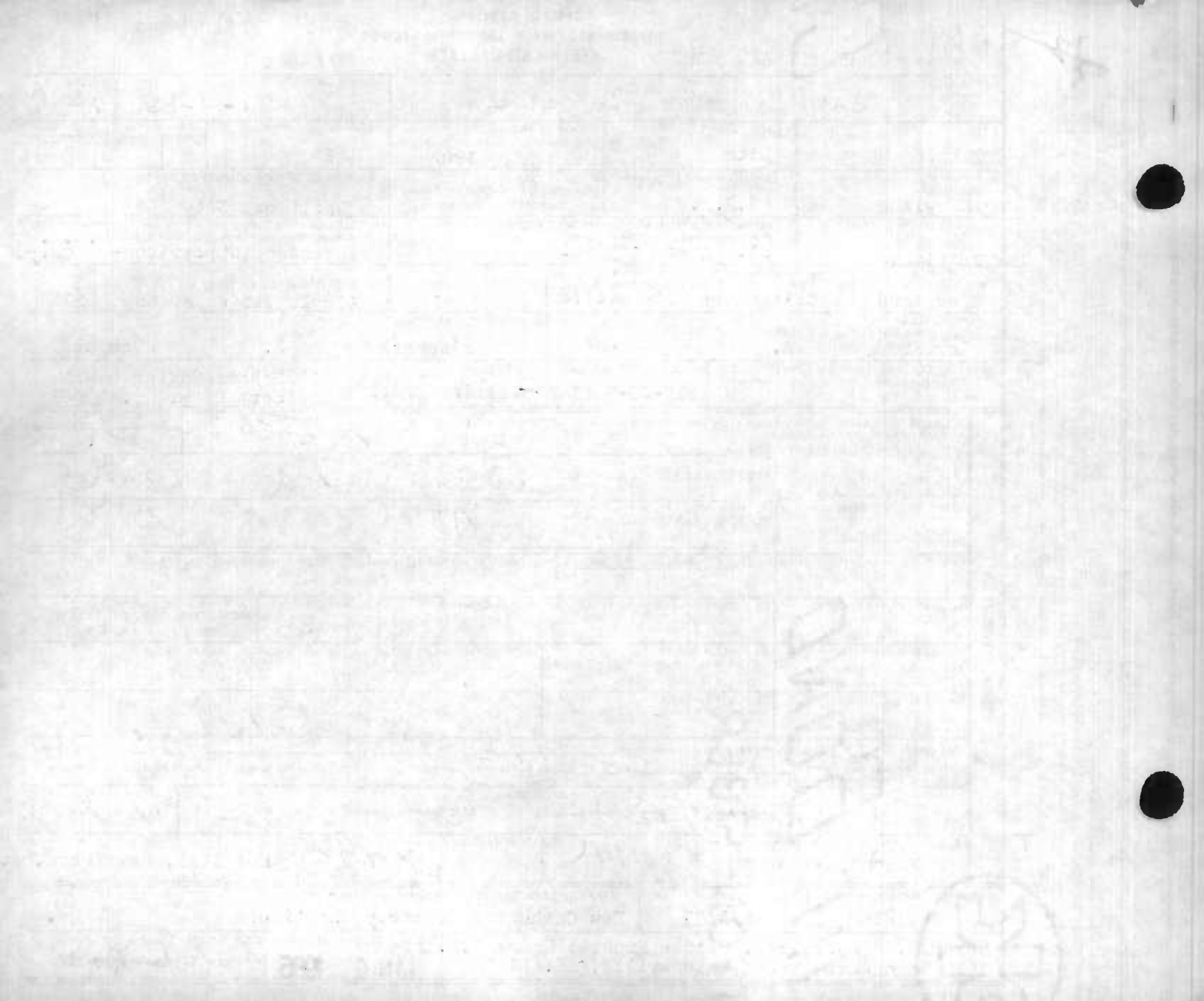
85

01509

1- FOR  
STATE REGISTRAR JOHN BERNARD SCHENE

REG. NO.

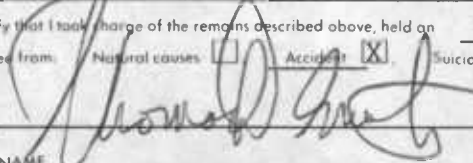
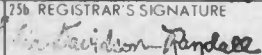
|   |  |  |   |   |                        |  |
|---|--|--|---|---|------------------------|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>FIRST MIDDLE LAST<br>John BERNARD Schene   |  |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br>1-2-85 |   | 2b. HOUR<br>630 A<br>M |  |
| 3. SEX<br>Male  |  | 4. RACE<br>White   |   | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>July 31, 1902   |                        |  |
| 6. AGE (IN YEARS LAST BIRTHDAY)<br>82 YRS   |  | 7. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Maryland   |   | 8. AGE (IN YEARS LAST BIRTHDAY)<br>IF UNDER 1 YEAR MONTHS DAYS<br>IF UNDER 24 HRS HOURS MIN.                                    |                        |  |
| 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Baltimore City MD.  |  | 10. CITY OR TOWN OF DEATH<br>Baltimore   |   | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>St. Agnes Hospital |                        |  |
| 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Maintenance Supervisor  |  | 12b. KIND OF BUSINESS OR INDUSTRY<br>D.C.A. Corp.  |   | 13. STREET ADDRESS / ZIP CODE<br>628 Ingleside Avenue 21228   |                        |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>Bernard A. Schene   |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Elizabeth S. ODonnel  |   | 16. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)<br>No                           |                        |  |
| 17. SOCIAL SECURITY NO.<br>218-03-9891 A  |  | 18. INFORMANT<br>William Small   |   | 19. ADDRESS<br>12333 Pans Spring Court<br>Ellicott City, Md. 21043  |                        |  |
| 11. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) _____<br>DUE TO, OR AS A CONSEQUENCE OF (b) _____<br>DUE TO, OR AS A CONSEQUENCE OF (c) _____<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. |  |  |   |   |                        |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a  |  |  |   |   |                        |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>   |                        |  |
| 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>  |  | 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |   | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |                        |  |
| 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)   |  | 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  |   | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |                        |  |
| 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  | 22a. I certify that (I) (this hospital) attended the deceased from 1/2 1985 to 1/5 1985, that (I) (we) lost saw the deceased alive on 1/2 1985, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. |   | 22b. SIGNATURE<br>DEGREE<br>1/5/85  |                        |  |
| 22c. DATE SIGNED  |  | 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>J. B. Schene  |   | 22e. ADDRESS<br>St. Agnes Hospital, Baltimore, Md.  |                        |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br>Burial  |  | 23b. DATE<br>1/5/85  |   | 23c. NAME OF CEMETERY OR CREMATORY<br>New Cathedral Cemetery  |                        |  |
| 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Baltimore Md.   |  | 24. FUNERAL DIRECTOR<br>NAME<br>Leroy M. & Russell C. Witzke Funeral Homes P.A.<br>1630 Mondson Avenue, Catonsville, Md. 21228   |   | 25a. DATE REC'D. BY REGISTRAR<br>JAN 4 1985   |                        |  |
| 25b. REGISTRAR'S SIGNATURE<br>Julia Davidson-Randall  |  |  |   |   |                        |  |





**STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH**

REG. NO.

|  |  |                             |  |   |  |   |  |   |  |   |  |   |  |   |  |
|--|--|-----------------------------|--|---|--|---|--|---|--|---|--|---|--|---|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>John W. Schindele</b>   |  |                             |  |   |  |   |  |   |  | 2a. DATE KNOWN OF DEATH<br>ESTIMATED <input checked="" type="checkbox"/> MONTH DAY YEAR <b>1 4 19 85</b>            |  | 2b. HOUR<br>M <b>7:25</b> AM  |  |   |  |
| 1. SEX<br><b>male</b>  |  | 4. RACE<br><b>caucasian</b> |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR <b>1 13 36</b>   |  | 6. AGE (IN YEARS)<br>LAST BIRTHDAY YRS. <b>48</b>                       |  | IF UNDER 1 YR.<br>MONTHS DAYS HOURS MIN   |  | 7c. DATE PRONOUNCED DEAD<br>MONTH DAY YEAR <b>1 4 19 85</b>   |  | 7d. HOUR<br>P <b>7:25</b> AM  |  |   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Maryland</b>   |  |                             |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>   |  |   |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  |   |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore City, MD.</b>                  |  |   |  |
| 10. CITY OR TOWN OF DEATH<br><b>Baltimore</b>  |  |                             |  | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>St. Agnes Hospital</b> |  |   |  |   |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>truck driver</b>                                |  |   |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>car shipper</b> |  |
| 13a. STATE<br><b>Maryland</b>  |  |                             |  |   |  | 13b. COUNTY<br><b>Howard</b>  |  | 13c. CITY OR TOWN<br><b>Savage</b>  |  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                     |  | 13e. STREET ADDRESS<br><b>P.O. Box 168 20763</b>                                    |  |   |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Christopher W. Schindele</b>  |  |                             |  |   |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Esther M. Amend</b> |  |   |  |   |  |   |  |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO, OR UNKNOWN) LIVES GIVE WAR OR DATES<br><b>yes 7/53-5/64</b>  |  |                             |  |   |  | 16b. SOCIAL SECURITY NO.<br><b>212 32 5992</b>                          |  | 17. INFORMANT<br>ADDRESS<br><b>Mary B. Schindele Savage, Md. 20763</b>  |  |   |  |   |  |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Multiple injuries</b><br>8/20<br>Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH                        |  |                             |  |   |  |   |  |   |  |   |  |   |  |   |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 18i.  |  |                             |  |   |  |   |  |   |  |   |  |   |  |   |  |
| 19a. DATE OF OPERATION   |  |                             |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?   |  |   |  |   |  |   |  | 20. AUTOPSY?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |   |  |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH   |  |                             |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>6:15 A.M. 1 4 19 85</b>   |  |   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)<br><b>Driver in auto/tractor trailer impact</b>                               |  |   |  |   |  |   |  |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>  |  |                             |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)<br><b>road</b>  |  |   |  | 21f. LOCATION<br>STREET<br><b>Washington Blvd</b>   |  | CITY OR TOWN<br><b>Balto. Co.</b>   |  | COUNTY<br><b>Md.</b>  |  |   |  |
| 22a. I certify that I took charge of the remains described above, held on death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion |  |                             |  |   |  |   |  |   |  |   |  |   |  |   |  |
| ACTUAL SIGNATURE<br>   |  |                             |  | TITLE (SPECIFY)<br><b>M.D. Acting Chief</b>   |  |   |  | DATE SIGNED<br><b>1/5/85</b>  |  |   |  |   |  |   |  |
| EXAMINER'S NAME (TYPE OR PRINT)<br><b>Thomas D. Smith, M.D.</b>  |  |                             |  | ADDRESS<br><b>111 Penn St.</b>  |  |   |  | BALTO., MD.   |  |   |  |   |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>burial</b>   |  |                             |  | 23b. DATE<br><b>1/8/85</b>  |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Meadowridge Mem. Park</b>      |  |   |  | 23d. LOCATION<br>CITY OR TOWN<br><b>Elkridge</b>  |  |   |  |   |  |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>Gary L. Kaufman</b>   |  |                             |  | ADDRESS<br><b>5695 Main St. Elkridge, Md. 21227</b>   |  |   |  | 25a. DATE REC'D. BY REGISTRAR<br><b>JAN 8 1985</b>  |  | 25b. REGISTRAR'S SIGNATURE<br> |  |   |  |   |  |

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR RECORDS. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201





100% COTTON TIBET

100% COTTON TIBET

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial/transfer permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 2 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 5 0 1 5 1 1

FOR  
1 - STATE  
REGISTRAR

REG. NO.

|  |  |   |   |   |  |   |
|--|--|---|---|---|--|---|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>FIRST MIDDLE LAST<br><b>MARY J. SCHMIDT</b>   |  |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>01 29 1985</b>                |   | 2b. HOUR<br><b>2:15PM</b>              |   |
| 3. SEX<br><b>FEMALE</b>  |  | 4. RACE<br><b>WHITE</b>   |   | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>03 03 1906</b>   |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>78</b> YRS.   |
| 7. BIRTHPLACE (STATE OR FOREIGN)<br><b>MARYLAND</b>  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>  |   | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>BALTIMORE CITY</b> MD.   |
| 10. CITY OR TOWN OF DEATH<br><b>BALTIMORE</b>  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>ST AGNES HOSPITAL</b> |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>HOMEMAKER</b>  |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>---</b>   |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE<br><b>MARYLAND</b>  |  |   | 13b. COUNTY<br><b>BALTIMORE</b>   |   | 13c. CITY OR TOWN<br><b>HALETHORPE</b> |   |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>JOSEPH APPELEGATE</b>   |  |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>KATHERINE DIXON</b> |   |  |   |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>NO</b>  |  | 16b. SOCIAL SECURITY NO.<br><b>228-22-7394</b>  |   | 17. INFORMANT<br>ADDRESS<br><b>HELEN J. SCHMIDT 1617 SUMMIT AVENUE, 21227</b>   |  |   |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY<br>IMMEDIATE CAUSE (a) <u>Cordian arrest</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <u>reported cigarette/tobacco abuse</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <u>stroke aneurysm</u>                       |  |   |   |   |  | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH   |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a   |  |   |   |   |  |   |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  | 20b. IF YES, WERE FINDINGS USED<br>IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)  |  |   |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |   |
| 22a. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) lost<br>saw the deceased alive on _____, 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated<br>above, (I) (we) (did/did not) view the body after death. |  |   |   |   |  |   |
| 22b. SIGNATURE<br><i>Dr. Acevedo</i>   |  |   |   | DEGREE<br>ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>        |  | 22c. DATE SIGNED<br><b>1/29/85</b>  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>Acevedo</b>  |  |   |   | 22e. ADDRESS<br><b>Saint Agnes Hospital</b>   |  |   |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>BURIAL</b>  |  | 23b. DATE<br><b>02-02-85</b>  |   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>LOUDON PARK</b>  |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>BALTIMORE CITY BALTIMORE MARYLAND</b>  |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>HUBBARD FUNERAL HOME, INC.</b>  |  |   |   | ADDRESS<br><b>4107 WILKENS AVE.</b>   |  | 25a. DATE REC'D. BY REGISTRAR<br><b>1985</b>  |
|  |  |   |   |   |  | 25b. REGISTRAR'S SIGNATURE  |

BP

UNITED STATES  
DEPARTMENT OF JUSTICE  
FEDERAL BUREAU OF INVESTIGATION

TO: SAC, NEW YORK

FROM: SAC, NEW YORK

SUBJECT: [Illegible]

(A)

RE: [Illegible]

DATE: [Illegible]

REFERENCE: [Illegible]

ADMINISTRATIVE: [Illegible]

OTHER: [Illegible]

REMARKS: [Illegible]

DISCUSSION: [Illegible]

CONCLUSIONS: [Illegible]

RECOMMENDATIONS: [Illegible]

ADMINISTRATIVE: [Illegible]

OTHER: [Illegible]

REMARKS: [Illegible]

DISCUSSION: [Illegible]

CONCLUSIONS: [Illegible]

RECOMMENDATIONS: [Illegible]

ADMINISTRATIVE: [Illegible]

OTHER: [Illegible]

REMARKS: [Illegible]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 4 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH  |  |   |  | REG. NO.  |  |  |  |
|---|--|---|--|---|--|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>Rebecca Schnaper</b>   |  |   |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR <b>1 21 85</b> 2b. HOUR <b>2:00 PM</b>  |  |  |  |
| 3 SEX <b>FEMALE</b>   |  | 4 RACE <b>WHITE</b>   |  | 5. DATE OF BIRTH <b>1899</b><br>MONTH DAY YEAR <b>12 28 1899</b>  |  | 6. AGE (IN YEARS LAST BIRTHDAY) <b>85</b><br>MONTHS DAYS HOURS MIN.  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>POLAND</b>   |  | 7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>             |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore CITY MD.</b>  |  |
| 10. CITY OR TOWN OF DEATH<br><b>Baltimore</b>   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Pleasant Manor Nursing Center</b> |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>HOUSEWIFE</b>  |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>AT HOME</b>  |  |
| 13a. STATE <b>Md.</b> 13b. COUNTY <b>BALTO.</b> 13c. CITY OR TOWN <b>BALTO.</b>   |  |   |  | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>  |  |  |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST <b>UNKNOWN GROSSINGER</b>  |  |   |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST <b>UNKNOWN</b>  |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) <b>NO</b>  |  | 16b. SOCIAL SECURITY NO.<br><b>214-34-3178</b>  |  | 17. INFORMANT <b>BERNARD D. SCHNAPER</b><br><b>Pleasant Manor Nursing Center</b><br><b>4615 Park Heights Ave. Baltimore, Md.</b><br><b>7209 BROOKCREST WAY, APT. B2</b> |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Alzheimer's Disease</b><br>DUE TO, OR AS A CONSEQUENCE OF (b) _____<br>DUE TO, OR AS A CONSEQUENCE OF (c) _____<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last |  |   |  | 18b. INTERVAL BETWEEN ONSET AND DEATH<br><b>10 years</b>  |  |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: (a)<br><b>Carcinoma of tongue</b>  |  |   |  |   |  |  |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)  |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |  |  |
| 22. I certify that (I) (this hospital) attended the deceased from <b>July 23, 1975</b> to <b>January 21, 1985</b> , that (I) (we) last saw the deceased alive on <b>January 2, 1985</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.  |  |   |  |   |  |  |  |
| 22b. SIGNATURE <b>Manuel Levin MD</b>   |  |   |  | 22c. DEGREE <b>MD</b>   |  | 22d. DATE SIGNED <b>1/21/85</b>  |  |
| 22e. PHYSICIAN'S NAME (TYPE OR PRINT) <b>MANUEL LEVIN, M.D.</b>   |  |   |  | 22f. ADDRESS <b>6101 PK HTS AVE BALTO MD 21215</b>  |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>BURIAL</b>   |  | 23b. DATE <b>JAN. 23, 1985</b>  |  | 23c. NAME OF CEMETERY OR CREMATORY <b>FORBAND</b>   |  | 23d. LOCATION <b>ROSEDALE BALTO. MD</b>  |  |
| 24. FUNERAL DIRECTOR <b>SOL LEVINSON &amp; BROS., INC.</b><br>NAME ADDRESS <b>6010 REISTERSTOWN RD. BALTO., MD 21215</b>  |  |   |  | 25a. DATE REC'D. BY REGISTRAR <b>JAN 25 1985</b>  |  | 25b. REGISTRAR'S SIGNATURE <b>[Signature]</b>  |  |



STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8501513

1- FOR  
STATE  
REGISTRAR

REG. NO.

|   |  |   |   |  |  |
|---|--|---|---|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>HENRY R. SCHNITZKER</b>  |  |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>1/01/85</b>   |  | 2b. HOUR<br><b>7:23 AM</b>   |
| 3. SEX<br><b>M</b>  | 4. RACE<br><b>W</b>  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>10-24-1914</b>   | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>70</b> YRS.   | IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS<br>HOURS MIN.                    |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>MARYLAND</b>  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>BALTIMORE CITY</b> MD.                               |  |  |
| 10. CITY OR TOWN OF DEATH<br><b>BALTO.</b>  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>GOOD SAMARITAN HOSP.</b> |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>FIRE CHIEF</b>           | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>GOVERNMENT</b>                             |  |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE <b>MD.</b> 13b. COUNTY <b>---</b> 13c. CITY OR TOWN <b>BALTO.</b>  |  |   | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | 13e. STREET ADDRESS / ZIP CODE<br><b>806 QUAIL ST. 21224</b>                       |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>RUDOLPH H. SCHNITZKER</b>  |  |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>MARTHA KOPPS</b>                            |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>YES</b>  |  | 16b. SOCIAL SECURITY NO.<br><b>W. W. II 213-05-2213</b>   | 17. INFORMANT<br>ADDRESS<br><b>Mr. Vivian M. Schnitzker - 806 Quail St. 21224</b>               |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Acute Myocardial Infarction</b><br>DUE TO, OR AS A CONSEQUENCE OF (b) <b>Severe Cong. Aortic Failure</b><br>DUE TO, OR AS A CONSEQUENCE OF (c) <b>---</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. |  |   |   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>1 Week</b>  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)<br><b>Previous Myocardial Infarction</b>  |  |   |   |  |  |
| 19a. DATE OF OPERATION<br><b>11-5-84</b>  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED<br><b>3-84</b>   |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>          | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER NOTIFY MEDICAL EXAMINER)   | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>19</b>   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18: PART I OR PART 2)  |   |  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE<br><b>929 S. Charles St. BALTO. MD.</b>   |   |  |  |
| 22a. I certify that (1) (this hospital) attended the deceased from above (1) (we) (did) (did not) view the body after death.  |  |   |   |  |  |
| 22b. SIGNATURE OF<br>THE PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>THEODORE W. NICHOLS</b>   |  | DEGREE<br><b>M.D.</b>   | ATTENDING PHYSICIAN<br><b>THEODORE W. NICHOLS</b>   | MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | 22c. DATE SIGNED<br><b>1-24-85</b>   |
| 23a. BURIAL CREMATION, REMOVAL<br>(SPECIFY)<br><b>BURIAL</b>  |  | 23b. DATE<br><b>1-5-85</b>  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>FIRST UNITED CHURCH</b>                                |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>BALTO. MD.</b>  |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>John J. Green - 2334 Jefferson St.</b>   |  |   | 25a. DATE REC'D. BY REGISTRAR<br><b>JAN 4 1985</b>  |  |  |
| 25b. REGISTRAR'S SIGNATURE<br><b>John Davidson-Randall</b>  |  |   |   |  |  |

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MEDICAL CERTIFICATION

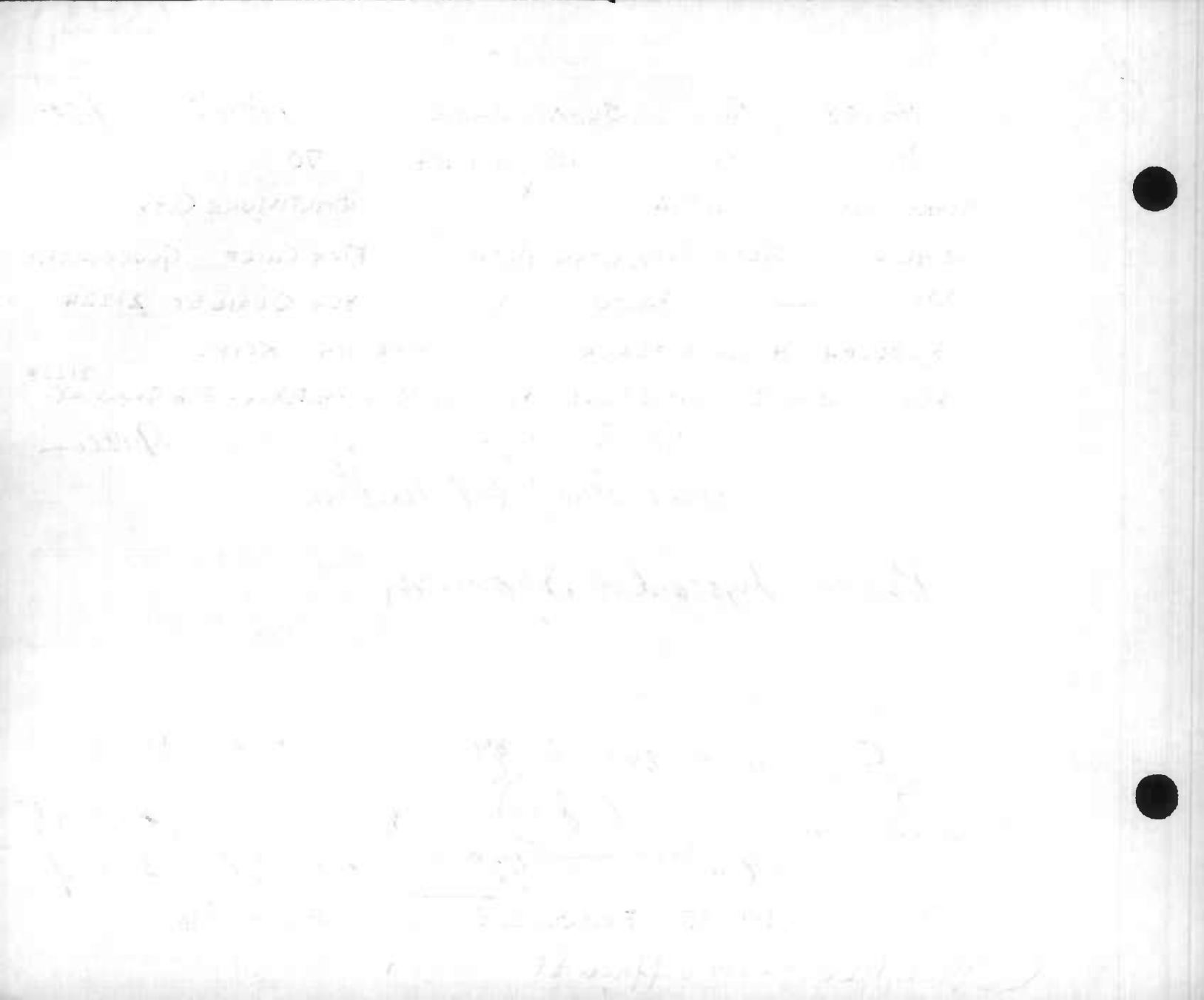
9

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.





STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8501514

1- FOR  
STATE  
REGISTRAR

REG. NO.

|   |  |   |  |   |                                      |  |  |
|---|--|---|--|---|--------------------------------------|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT) <del>XXXXXXXXXX</del> <b>FRIEDA</b> <del>XXXXXXXXXX</del> <b>SCHRAGO</b>  |  |   | 2a. DATE OF DEATH MONTH DAY YEAR<br><b>1 12 85</b> |   | 2b. HOUR<br><b>6<sup>00</sup> AM</b> |  |  |
| 3. SEX<br><b>F</b> <b>EMALE</b>   |  | 4. RACE<br><b>W</b> <b>HITE</b>   |  | 5. DATE OF BIRTH MONTH DAY YEAR<br><b>12 12 1913</b>  |                                      | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>XXX</b> <b>71</b> YRS.   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>MARYLAND</b>  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |                                      | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Balti city</b> MD.  |  |
| 10. CITY OR TOWN OF DEATH<br><b>BALTO</b>   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>SINAI HOSPITAL</b>  |  |   |                                      | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>CLERICAL</b>  |  |
| 12b. KIND OF BUSINESS OR INDUSTRY<br><b>PAWN SHOP</b>   |  | 13a. STREET ADDRESS<br><b>5715 PARK HEIGHTS AVE.</b>  |  | 13b. CITY OR TOWN<br><b>BALTO</b>   |                                      | 13c. STATE<br><b>MD</b>  |  |
| 14. FATHER'S NAME FIRST MIDDLE LAST<br><b>WILLIAM</b> <b>SCHRAGO</b>  |  | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST<br><b>ROSE</b> <b>PODHOZER</b>   |  | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>NO</b>   |                                      | 16b. SOCIAL SECURITY NO.<br><b>213-20-7746</b>   |  |
| 17. INFORMANT ADDRESS<br><b>TOWSON, MD 21204</b>  |  | 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>CARDIAC ARREST</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last<br>(b) <b>Prolonged SICKNESS</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____<br>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: (a)<br><b>LTM/LOM, CORONARY AR DISEASE</b> |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>1 yr</b>   |                                      |  |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>   |                                      | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18: PART I OR PART 2)  |                                      | 21d. LOCATION CITY OR TOWN COUNTY STATE<br><b>BALTIMORE MARYLAND</b>   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>1/11</b> 19 <b>85</b> to <b>1/12</b> 19 <b>85</b> , that (I) (we) lost<br>saw the deceased alive on <b>1/12/85</b> 19 <b>85</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated<br>above, (I) (we) (did) not view the body after death. |  | 22b. SIGNATURE<br><b>Arnold D. Goldberg</b>   |  | 22c. DATE SIGNED<br><b>1/12/85</b>  |                                      | 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>Arnold D. Goldberg</b>   |  |
| 22e. ADDRESS<br><b>SINAI HOSPITAL OF BALTO</b>  |  | 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>BURIAL</b>  |  | 23b. DATE<br><b>1/14/85</b>   |                                      | 23c. NAME OF CEMETERY OR CREMATORY<br><b>WORKMEN CIRCLE CEM</b>  |  |
| 23d. LOCATION CITY OR TOWN COUNTY STATE<br><b>BALTIMORE MARYLAND</b>  |  | 24. FUNERAL DIRECTOR<br>NAME <b>SOL LEVINSON &amp; BROS., INC.</b><br>ADDRESS <b>6010 REISTERSTOWN RD. BALTIMORE MARYLAND 21215</b>   |  | 25a. DATE REC'D. BY REGISTRAR<br><b>JAN 17 1985</b>   |                                      | 25b. REGISTRAR'S SIGNATURE<br><b>Kelia Davidson-Randall</b>  |  |

MEDICAL CERTIFICATION

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IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1- FOR  
STATE  
REGISTRAR

|   |   |   |  |  |  |
|---|---|---|--|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>ANNA R. SCHWINGER</b>  |   |   | 2a. DATE OF DEATH<br>MONTH <b>01</b> DAY <b>19</b> YEAR <b>85</b> 2b. HOUR <b>10</b> MIN. <b>4</b> |  |  |
| 3. SEX<br><b>Female</b>   | 4. RACE<br><b>White</b>   | 5. DATE OF BIRTH<br>MONTH <b>Sept.</b> DAY <b>7</b> YEAR <b>1907</b>  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>77</b> YRS.  | 7. IF UNDER 1 YEAR<br>MONTHS <b></b> DAYS <b></b> HOURS <b></b> MIN. <b></b>         |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>MD</b>  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore City</b> MD.                                  |  |  |
| 10. CITY OR TOWN OF DEATH<br><b>Baltimore</b>   | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Union Memorial Hospital</b> |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Homemaker</b>               | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>Own Home</b>                                 |  |
| 13a. STATE<br><b>MD</b>   |   |   | 13b. COUNTY<br><b>Baltimore</b>  | 13c. CITY OR TOWN<br><b>Baltimore</b>  |  |
| 14. FATHER'S NAME<br>FIRST <b>Thomas</b> MIDDLE <b>J.</b> LAST <b>Thompson</b>  |   |   | 15. MOTHER'S MAIDEN NAME<br>FIRST <b>Anna</b> MIDDLE <b></b> LAST <b>Kaylor</b>                    |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>No</b>   |   | 16b. SOCIAL SECURITY NO.<br><b></b>   |  | 17. INFORMANT<br>ADDRESS<br><b>Donald A. Williams, Richmond, VA</b>                  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Cardiac Arrest</b><br>DUE TO, OR AS A CONSEQUENCE OF (b) <b></b><br>DUE TO, OR AS A CONSEQUENCE OF (c) <b></b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.  |   |   |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: <b>Rheumatoid arthritis, Chronic Lymphocytic Leukemia</b>  |   |   |  |  |  |
| 19a. DATE OF OPERATION<br><b>1/11/85</b>  |   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED<br><b>Duodenal Ulcer</b>   |  | 20a. AUTOPSY?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |
| 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |   |   |  |  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |   | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. <b>19</b>   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)        |  |
| 21d. INJURY OCCURRED<br>WHERE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK   |   | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                    |  |
| 22a. I certify that (I) this hospital attended the deceased from <b>1/8</b> , 19 <b>85</b> , to <b>1/19</b> , 19 <b>85</b> , that (I) (we) lost saw the deceased alive on <b>1/19</b> , 19 <b>85</b> , and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) did not view the body after death. |   |   |  |  |  |
| 22b. SIGNATURE<br><b>Rob Robert A. Miller</b>   |   | DEGREE <b>MD</b> ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> |  | 22c. DATE SIGNED<br><b>1/19/85</b>   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>Robert A. Miller, MD</b>  |   | 22e. ADDRESS<br><b>Union Memorial Hospital, Balto., MD</b>  |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>Burial</b>   |   | 23b. DATE<br><b>1/21/85</b>   |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Lorraine Park</b>                           |  |
| 23d. LOCATION<br>CITY OR TOWN<br><b>Balto., MD</b>  |   | 23e. COUNTY<br><b>MD</b>  |  |  |  |
| 24. FUNERAL DIRECTOR<br>NAME <b>Henry W. Jenkins &amp; Sons Co.</b> ADDRESS <b>4905 York Road Balto., MD 21212</b>  |   |   | 25a. DATE REC'D. BY REGISTRAR<br><b>JAN 21 1985</b>  |  |  |
| 25b. REGISTRAR'S SIGNATURE<br><b>Julia Davidson-Randall</b>   |   |   |  |  |  |

BP

1  
(1)

01 10 87 10

Sept. 7, 1907

White

Female

USA

MD

House skin  
21.82

8101 Rock River Biv.

Baltimore

MD

Kaylor

Anna

Thompson

J.

Thomas

Donald A. Williams, Richmond, VA

No

White

DATE

100%

100% of the total

100% of the total

Robert A. Miller, MD

Union Memorial Hospital, Baltimore, MD

MD

1907

1907

1907

1907

1907

1907

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon-topper. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

85 01516

1. FOR  
STATE  
REGISTRAR

REG. NO.

|  |  |  |  |   |   |   |  |  |   |  |
|--|--|--|--|---|---|---|--|--|---|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>FIRST MIDDLE LAST<br><b>JEROME STEVENSON SCOTT</b>  |  |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>01 07 85</b>                 |   |   | 2b. HOUR<br><b>210 P</b><br>M   |  |  |   |  |
| 3. SEX<br><b>male</b>  |  | 4. RACE<br><b>black</b>  |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>11 17 1899</b>   |   | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>85</b><br>YRS.                                |  | 7. IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS<br>HOURS MIN.   |   |  |
| 7b. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>md.</b>  |  | 7c. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>   |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>BALTO. CITY</b><br>MD.                   |  |  |   |  |
| 10. CITY OR TOWN OF DEATH<br><b>BALTO</b>  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>MERCY HOSP</b> |  |   |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>MECHANIC</b> |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>U.S. P.O.</b>  |   |  |
| 13a. STATE<br><b>md.</b>   |  |  | 13b. COUNTY<br><b>BALTIMORE</b>  |   | 13c. CITY OR TOWN<br><b>BALTIMORE</b>                         |   | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  | 13e. STREET ADDRESS<br><b>6004 PRESTON AVE.</b> |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST   |  |  |  |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST                 |   |  |  |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>no</b>  |  |  | 16b. SOCIAL SECURITY NO.   |   | 17. INFORMANT<br>ADDRESS<br><b>BESSIE SCOTT 51A</b>           |   |  |  |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>myocardial heart failure</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(b) <b>chronic renal failure</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____<br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>3 days</b><br><b>months to years</b> |  |  |  |   |   |   |  |  |   |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)  |  |  |  |   |   |   |  |  |   |  |
| 19a. DATE OF OPERATION   |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                       |   |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>           |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |   |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19             |   |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)      |  |  |   |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK   |  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) |   |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                   |  |  |   |  |
| 22a. I certify that (1) (this hospital) attended the deceased from <b>Jan 3rd</b> , 19 <b>85</b> , to <b>Jan 7th</b> , 19 <b>85</b> , that (1) (we) lost saw the deceased alive on <b>Jan 7th</b> , 19 <b>85</b> , and that in my (our) opinion death occurred on the date and hour and from the causes stated above, (1) (we) (did) (did not) view the body after death.  |  |  |  |   |   |   |  |  |   |  |
| 22b. SIGNATURE<br><b>Ben Tachem MD</b>   |  |  |  |   | DEGREE  |   | 22c. DATE SIGNED<br><b>1/7/85</b>  |  |   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>B TACHERON MD</b>  |  |  |  |   | 22e. ADDRESS<br><b>301 ST PAUL PL BALTIMORE MD</b>            |   |  |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>BURIAL</b>  |  |  | 23b. DATE<br><b>1/11/85</b>  |   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Mt. Zion AME Ch.</b> |   | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>BALTO GREEN MD</b>                  |  |   |  |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>Chatman-Harris FH</b>   |  |  |  |   | ADDRESS<br><b>1701 McGall St</b>                              |   | 25a. DATE REC'D. BY REGISTRAR<br><b>JAN 10 1985</b>                                  |  |   |  |
| 25b. REGISTRAR'S SIGNATURE   |  |  |  |   |   |   |  |  |   |  |

MEDICAL CERTIFICATION

BP.

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1. The first part of the report is a summary of the work done during the year. It is divided into two main sections: a general summary and a summary of the work done in each of the four departments. The general summary is divided into three parts: a summary of the work done in the first half of the year, a summary of the work done in the second half of the year, and a summary of the work done in the whole year. The summary of the work done in each of the four departments is divided into two parts: a summary of the work done in the first half of the year and a summary of the work done in the second half of the year. The second part of the report is a detailed account of the work done in each of the four departments. It is divided into four main sections: a detailed account of the work done in the first department, a detailed account of the work done in the second department, a detailed account of the work done in the third department, and a detailed account of the work done in the fourth department. Each of these sections is divided into two parts: a summary of the work done in the first half of the year and a summary of the work done in the second half of the year. The third part of the report is a summary of the work done in each of the four departments during the year. It is divided into four main sections: a summary of the work done in the first department, a summary of the work done in the second department, a summary of the work done in the third department, and a summary of the work done in the fourth department. Each of these sections is divided into two parts: a summary of the work done in the first half of the year and a summary of the work done in the second half of the year. The fourth part of the report is a summary of the work done in each of the four departments during the year. It is divided into four main sections: a summary of the work done in the first department, a summary of the work done in the second department, a summary of the work done in the third department, and a summary of the work done in the fourth department. Each of these sections is divided into two parts: a summary of the work done in the first half of the year and a summary of the work done in the second half of the year.



STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8501517

1- FOR  
STATE  
REGISTRAR

REG. NO.

|  |  |   |  |   |   |
|--|--|---|--|---|---|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>FIRST MIDDLE LAST<br><b>John S Scott</b>              |  |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>1 1 85</b>                                   |   | 2b. HOUR<br><b>1:20 AM</b>  |
| 3. SEX<br><b>MALE</b>  | 4. RACE<br><b>BLACK</b>  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>07-04-18</b>   |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>66</b> YRS. | IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS.<br>HOURS MIN.                                |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>MD.</b>                                      | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>  | 8. MARRIED <input checked="" type="checkbox"/> <b>WIDOWED</b> <input type="checkbox"/> <b>DIVORCED</b> <input type="checkbox"/> | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore City</b> MD.                      |   |   |
| 10. CITY OR TOWN OF DEATH<br><b>BALTIMORE</b>  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>BON SECOURS Hospital</b> |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Disability.</b> |   | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>ret.</b>  |
| 13a. STATE<br><b>MD.</b>   |  |   | 13b. COUNTY<br><b>Baltimore</b>  | 13c. CITY OR TOWN<br><b>Baltimore</b>             | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Unavail John Scott Sr.</b>                      |  |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE<br><b>Unavail Agnes Valentine</b>             |   |   |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>Yes 733374823</b> |  |   | 16b. SOCIAL SECURITY NO.<br><b>218-07 3340A</b>  |   | 17. INFORMANT<br>ADDRESS<br><b>Beulah Scott, 1400 E. Madison Ave. Apt 711</b>                   |

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)  
PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) **SHOCK poss. 2° to SEPSIS**

DUE TO, OR AS A CONSEQUENCE OF

(b) **ACUTE RENAL FAILURE**

DUE TO, OR AS A CONSEQUENCE OF

(c) **ACUTE RESPIRATORY FAILURE**

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: **H/O CHRONIC PANCREATITIS, DUODENAL ULCER**

MEDICAL CERTIFICATION

|   |  |  |   |
|---|--|--|---|
| 19a. DATE OF OPERATION  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                       | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>  | 20b. IF YES, WERE FINDINGS USED<br>IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19             | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)   |   |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE  |   |
| 22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) lost<br>saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated<br>above, (I) (we) (did) (did not) view the body after death. |  |  |   |
| 22b. SIGNATURE<br><b>D. Shamsuddin</b>  | DEGREE<br><b>M.D.</b>  | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> | 22c. DATE SIGNED<br><b>01/01/85</b>   |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>D. SHAMSUDDIN</b>   |  | 22e. ADDRESS<br><b>BON SECOURS HOSPITAL</b>  |   |

|  |                            |   |   |
|--|----------------------------|---|---|
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>Burial</b>                                | 23b. DATE<br><b>1/7/85</b> | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Garrison Forest VA</b>                           | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Owings Mills, Maryland</b> |
| 24. FUNERAL DIRECTOR<br>NAME ADDRESS<br><b>Law Funeral Home 4611 Park Heights Ave. 21215</b> |                            | 25a. DATE REC'D. BY REGISTRAR 25b. REGISTRAR'S SIGNATURE<br><b>JAN 7 1985 [Signature]</b> |   |

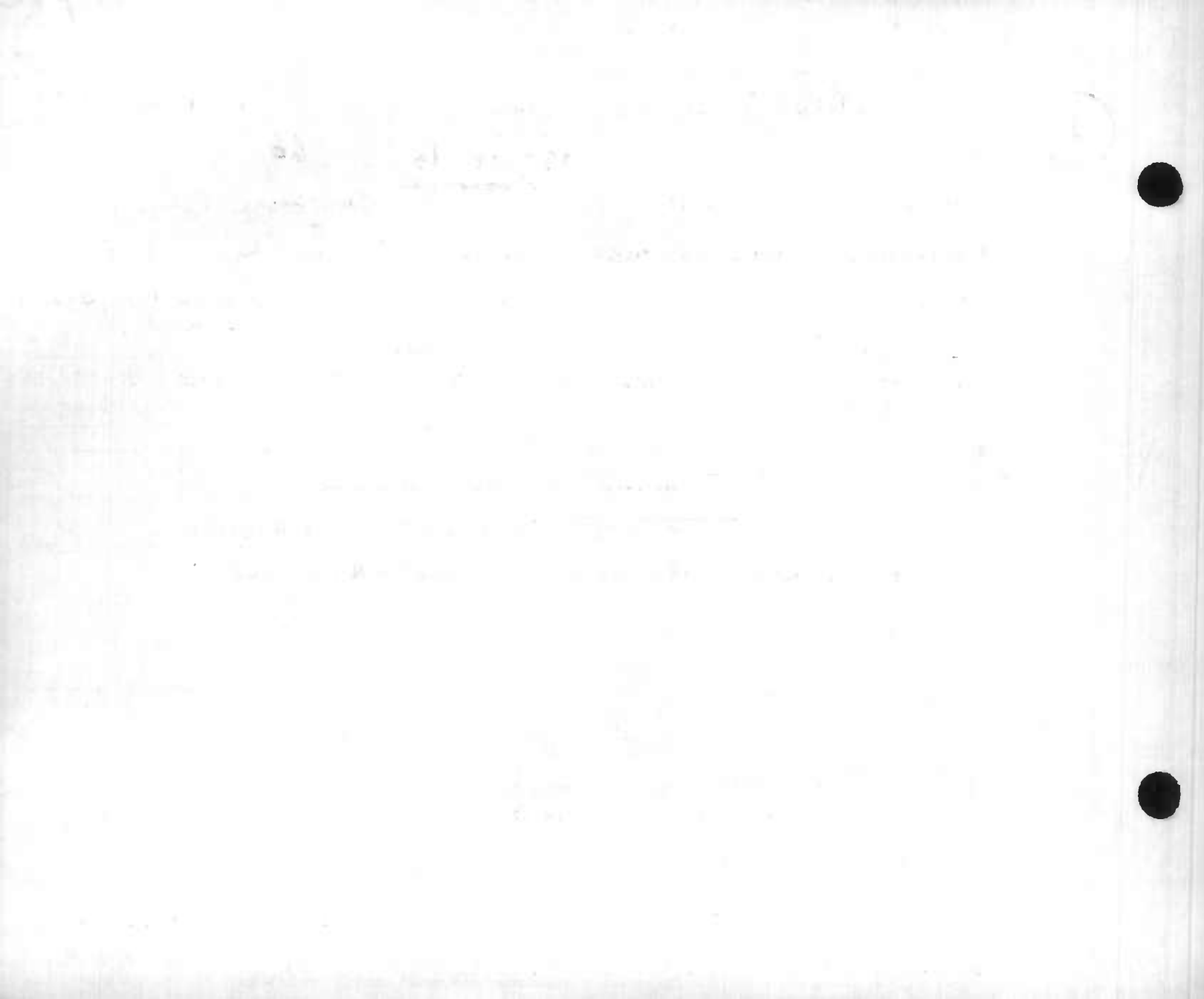
BP \_\_\_\_\_

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 4 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.  
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of once.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH   |  |  |  | REG. NO. 85 01518   |  |   |  |
|--|--|--|--|---|--|---|--|
| 1. FOR STATE REGISTRAR   |  |  |  |   |  |   |  |
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST<br><b>Patricia F. Scovens</b>   |  |  |  | 2a. DATE OF DEATH MONTH DAY YEAR<br><b>January 4, 1985</b>  |  | 2b. HOUR<br><b>4:45 AM</b>  |  |
| 3 SEX<br><b>Female</b>   |  | 4 RACE<br><b>Black</b>   |  | 5. DATE OF BIRTH MONTH DAY YEAR<br><b>11 4 25</b>   |  | 6. AGE (IN YEARS LAST BIRTHDAY) YRS.<br><b>59</b>   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>S. Carolina</b>  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>  |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore City</b> MD.   |  |
| 10. CITY OR TOWN OF DEATH<br><b>Baltimore</b>  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Maryland General Hospital</b> |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)   |  | 12b. KIND OF BUSINESS OR INDUSTRY   |  |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)  |  |  |  |   |  |   |  |
| 13a. STATE<br><b>Maryland</b>  |  | 13b. COUNTY  |  | 13c. CITY OR TOWN<br><b>Baltimore</b>   |  | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                            |  |
| 14. FATHER'S NAME FIRST MIDDLE LAST<br><b>- - -</b>  |  |  |  | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST<br><b>- - -</b>  |  |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)<br><b>NO</b>   |  | 16b. SOCIAL SECURITY NO.<br><b>217-38-7342</b>   |  | 17. INFORMANT ADDRESS<br><b>Earl Levi Holt 2300 Callow Avenue</b>   |  |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Cardiac Arrest</b><br>DUE TO, OR AS A CONSEQUENCE OF <b>Septic Shock and Disseminated Intravascular Coagulation</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>DUE TO, OR AS A CONSEQUENCE OF (c) <b>Spontaneous Bacterial Peritonitis</b>                                      |  |  |  |   |  |   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)<br><b>End Stage Liver Disease</b>   |  |  |  |   |  |   |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1B, PART I OR PART 2)  |  |   |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK   |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE  |  |   |  |
| 22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <b>January 3, 1985</b> , to <b>January 4, 1985</b> , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on <b>January 3, 1985</b> , and that in <input checked="" type="checkbox"/> (our) opinion death occurred on the date and hour and from the causes stated above, <input checked="" type="checkbox"/> (we) did not see the body after death. |  |  |  |   |  |   |  |
| 22b. SIGNATURE<br><i>[Signature]</i>   |  |  |  | DEGREE <b>MD</b> ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> |  | 22c. DATE SIGNED<br><b>1/4/85</b>   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>Jonathan D. Kushner, M.D.</b>  |  |  |  | 22e. ADDRESS<br><b>c/o Maryland General Hospital</b>  |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL<br><b>BURIAL</b>   |  | 23b. DATE<br><b>1/10/85</b>  |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Mount Zion Cemetery</b>  |  | 23d. LOCATION<br><b>Lansdowne, Md.</b> COUNTY STATE   |  |
| 24. FUNERAL DIRECTOR NAME<br><b>Wm C March F/H Inc.</b>  |  |  |  | 25a. DATE REC'D BY REGISTRAR<br><b>JAN 8 1985</b>   |  |   |  |
| ADDRESS<br><b>1101 E North Avenue</b>  |  |  |  | 25b. REGISTRAR'S SIGNATURE<br><i>[Signature]</i>  |  |   |  |



o/o Maryland General Hospital

January 3 1955  
January 4 1955  
January 5 1955

and severe liver disease

chronic hepatitis

intravascular coagulation

septic shock and disseminated

carotid artery

Michigan  
Maryland General Hospital

Baltimore City

January 1, 1955

Received

Exhibit



TO HOSPITAL OR ATTENDING PHYSICIAN. The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked, item 18, showing injury, or other traumatic event, the medical examiner or the coroner must be notified.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH   |  |  |  |   | REG. NO.  |  |   |  |   |  |  |
|--|--|--|--|---|---|--|---|--|---|--|--|
| 1. DECEASED NAME (TYPE OR PRINT)<br>Benjamin T. Seawell  |  |  |  |   | 2a. DATE OF DEATH MONTH DAY YEAR<br>January 18, 1985      |  |   |  | 2b. HOUR<br>1:13 <sup>A</sup>                   |  |  |
| 3. SEX<br>Male   |  | 4. RACE<br>White   |  | 5. DATE OF BIRTH MONTH DAY YEAR<br>1 10 1907  |   | 6. AGE (IN YEARS LAST BIRTHDAY)<br>78 YRS                                      |   | IF UNDER 1 YEAR<br>MONTHS DAYS   |   | IF UNDER 24 HRS<br>HOURS MIN   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Virginia  |  | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.A.   |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Baltimore City MD.                     |   |  |   |  |  |
| 10. CITY OR TOWN OF DEATH<br>Baltimore   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>Francis Scott Key Med.Center |  |   |   | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Steel Worker  |   | 12b. KIND OF BUSINESS OR INDUSTRY<br>Beth. Steel   |   |  |  |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE<br>Maryland   |  |  |  |   | 13b. CITY OR TOWN<br>Baltimore                            |  | 13c. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  | 13d. STREET ADDRESS<br>249 Colgate Avenue 21222 |  |  |
| 14. FATHER'S NAME FIRST MIDDLE LAST<br>John Seawell  |  |  |  |   | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST<br>Nora Thomas |  |   |  |   |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)<br>No  |  |  |  |   | 16b. SOCIAL SECURITY NO.<br>213-07-2083                   |  | 17. INFORMANT ADDRESS<br>Juanita W. Seawell Same as 13e   |  |   |  |  |
| 18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c).<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>ASCD = failure</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____ |  |  |  |   |   |  |   |  |   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><u>13 yrs</u>  |  |
|  |  |  |  |   |   |  |   |  |   |  |  |
|  |  |  |  |   |   |  |   |  |   |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:<br><u>Sickle Cell Mellitus. Recurrent CVA</u>   |  |  |  |   |   |  |   |  |   |  |  |
| 19a. DATE OF OPERATION   |  |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |   |  |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>  |   | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |  |  |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR<br>P.M. 19   |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) |   |  |   |  |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  |  |  |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |   | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE                                 |   |  |   |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>206</u> 19 <u>1963</u> to <u>1-17</u> 19 <u>85</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.  |  |  |  |   |   |  |   |  |   |  |  |
| 22b. SIGNATURE<br><u>Wyman Wong</u>  |  |  |  |   |   | DEGREE<br><u>M.D.</u>  |   | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |   | 22c. DATE SIGNED   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>Wyman Wong, M.D.  |  |  |  |   |   | 22e. ADDRESS<br>6730 Holabird Ave. Balto., MD 21222                            |   |  |   |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br>Burial  |  |  |  | 23b. DATE<br>1/21/1985  |   | 23c. NAME OF CEMETERY OR CREMATORY<br>Moreland                                 |   | 23d. LOCATION CITY OR TOWN COUNTY STATE<br>Baltimore Maryland  |   |  |  |
| 24. FUNERAL DIRECTOR NAME<br>Duda-Ruck, Inc.   |  |  |  |   |   | ADDRESS<br>7922 Wise Avenue Dundalk, MD. 21222                                 |   | 25a. DATE REC'D. BY REGISTRAR<br>JAN 22 1985   |   | 25b. REGISTRAR'S SIGNATURE<br><u>John Davidson Kendall</u>   |  |



STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

85 01520

1 - FOR  
STATE  
REGISTRAR

REG. NO.

|   |  |  |  |   |  |   |  |
|---|--|--|--|---|--|---|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>ELI F SEEGARD</b>                          |  |  | 2a. DATE OF DEATH MONTH DAY YEAR<br><b>Jan 31 1985</b> |   |  | 2b. HOUR<br><b>10:30 PM</b>   |  |
| 3. SEX<br><b>MALE</b>   |  | 4. RACE<br><b>WHITE</b>  |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>8 3 13</b>   |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>71</b> YRS  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Maryland</b>                      |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore City</b> MD.                               |  |
| 10. CITY OR TOWN OF DEATH<br><b>Baltimore City</b>                                |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Wyman Park Health System</b> |  |   |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Retired Seaman</b>       |  |
| 12b. KIND OF BUSINESS OR INDUSTRY<br><b>Merchant</b>                              |  | 13a. STREET ADDRESS / ZIP CODE<br><b>8108 Ridgetown Drive 21236</b>  |  |   |  |   |  |
| 13b. STATE<br><b>Maryland</b>   |  | 13c. COUNTY<br><b>BALTO</b>  |  | 13d. CITY OR TOWN<br><b>Baltimore City</b>  |  | 13e. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Jones</b>                            |  |  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Jones</b>   |  |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>No</b> |  | 16b. SOCIAL SECURITY NO.<br><b>216-07-0269</b>   |  | 17. INFORMANT<br>ADDRESS<br><b>Mr. Carroll Seegard - Same as #13</b>  |  |   |  |

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).  
PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) **CP Aneur**

DUE TO, OR AS A CONSEQUENCE OF

(b) **Large Cell Carcinoma Lung**

DUE TO, OR AS A CONSEQUENCE OF

(c)

APPROXIMATE INTERVAL  
BETWEEN ONSET AND DEATHPART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: **None**

MEDICAL CERTIFICATION

|  |  |  |  |  |  |   |  |
|--|--|--|--|--|--|---|--|
| 19a. DATE OF OPERATION:  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                       |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  | 20b. IF YES, WERE FINDINGS USED<br>IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>11 31 85</b>     |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)        |  |   |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                    |  |   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>1/31/85</b> to <b>1/31/85</b> , that (I) (we) last saw the deceased alive on <b>1/31/85</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. |  |  |  |  |  |   |  |
| 22b. SIGNATURE<br><b>Dan H. Schreiberfeder</b>   |  |  |  | DEGREE<br><b>MD</b>  |  | 22c. DATE SIGNED<br><b>1/31/85</b>  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>Dan H. SCHREIBFEDER</b>  |  |  |  | 22e. ADDRESS<br><b>WYMAN PARK Health System<br/>3100 WYMAN PARK DRIVE, BALTO, MD</b> |  |   |  |

|  |  |                            |  |   |  |  |  |
|--|--|----------------------------|--|---|--|--|--|
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>Removal</b> |  | 23b. DATE<br><b>2/1/85</b> |  | 23c. NAME OF CEMETERY OR CREMATORY                    |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE         |  |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>Anatomy Board</b>           |  |                            |  | ADDRESS<br><b>Balto., Md.</b>                         |  | 25a. DATE REC'D BY REGISTRAR<br><b>FEB 06 1985</b> |  |
|  |  |                            |  | 25b. REGISTRAR'S SIGNATURE<br><b>Davidson-Randall</b> |  |  |  |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury or other traumatic event, the medical examiner must be notified for autopsy.





0 038 42 32

DHMH - 18 60M 7/84  
(VRA 15, 4)

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be signed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 shows any injury, or other traumatic event, the medical examiner must be notified.

1- FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 5 0 1 5 2 1

REG. NO.

|   |  |   |   |  |   |
|---|--|---|---|--|---|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br><b>JULIUS SEIDEL</b>   |  |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>JANUARY 26, 1985</b>                                  |  | 2b. HOUR<br><b>3:58 P</b>                                       |
| 3. SEX<br><b>MALE</b>   | 4. RACE<br><b>WHITE</b>  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>DEC. 17, 1898</b>  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>86</b> YRS  |  | IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS<br>HOURS MIN. |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>LITHUANIA</b>   | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>   | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>BALTIMORE CITY</b> MD.                               |  |   |
| 10. CITY OR TOWN OF DEATH<br><b>BALTIMORE</b>   | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>JOHNS HOPKINS HOSPITAL</b> |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>WHOLESALE GROCER</b>     | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>FOOD</b>                         |   |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13b. STATE<br><b>NEW JERSEY</b> |  | 13c. CITY OR TOWN<br><b>PASSAIC</b>   | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 13e. STREET ADDRESS / ZIP CODE<br><b>347 AYCRIGG AVE. APT. B (07055)</b> |   |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>SAMUEL SEIDEL</b>  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>MARY KATZ</b>   |   |  |   |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>NO</b>   |  | 16b. SOCIAL SECURITY NO.<br><b>121-26-7388 A</b>  |   | 17. INFORMANT<br>ADDRESS<br><b>Columbia, Md. (21044)</b>                 |   |

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).  
PART I. DEATH WAS CAUSED BYIMMEDIATE CAUSE (a) **Respiratory Failure**

DUE TO, OR AS A CONSEQUENCE OF

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

(b) **TERMINAL PANCREATIC CARCINOMA**

DUE TO, OR AS A CONSEQUENCE OF

(c)

APPROXIMATE INTERVAL  
BETWEEN ONSET AND DEATH

3 days

23 days

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1. a

## MEDICAL CERTIFICATION

|  |  |  |  |
|--|--|--|--|
| 19a. DATE OF OPERATION   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)       |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>   | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                    |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>1/3/85</b> , 19 <b>85</b> , to <b>1/26</b> , 19 <b>85</b> , that (I) (we) lost saw the deceased alive on <b>1/26</b> , 19 <b>85</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |  |  |  |
| 22b. SIGNATURE<br><b>David W. Crist</b>  | DEGREE<br>ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |  | 22c. DATE SIGNED<br><b>1/26/85</b>   |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>CRIST, David</b>   |  | 22e. ADDRESS<br><b>JOHNS HOPKINS HOSPITAL</b>  |  |

|   |                             |   |  |
|---|-----------------------------|---|--|
| 23a. BURIAL OR REMOVAL<br>(SPECIFY)<br><b>REMOVAL</b>           | 23b. DATE<br><b>1/28/85</b> | 23c. NAME OF CEMETERY OR CREMATORY<br><b>KING SOLOMON CEM</b> | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>CLIFTON, N.J.</b> |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>SOL LEVINSON &amp; BROS.</b> |                             | 25a. DATE RECEIVED BY REGISTRAR<br><b>JAN 29 1985</b>         |  |
| 6010 REISTERSTOWN RD. BALTO., MD. (21215)                       |                             |   |  |



3-178

ВЕРИТЕЛЬНОЕ ПОСЛАНИЕ

ВЕРИТЕЛЬНОЕ ПОСЛАНИЕ

| FOR<br>1- STATE<br>REGISTRAR  |   | DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH   |  | 8 5 0 1 5 2 2  |  |
|---|---|---|--|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)   |   |   | 2a. DATE OF DEATH  |  | 2b. HOUR   |
| FIRST MIDDLE LAST<br>William NMN Seifert, Jr.   |   |   | MONTH DAY YEAR<br>January 28, 1985                               |  | 3:00 P.M.  |
| 3. SEX  | 4. RACE   | 5. DATE OF BIRTH  |  | 6. AGE (IN YEARS (LAST BIRTHDAY))  |  |
| Male  | White   | MONTH DAY YEAR<br>Aug. 28, 1925   |  | 59 YRS.  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)   | 7b. CITIZEN OF WHAT COUNTRY?  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH   |  |
| Balto. Maryland   | U.S.A.  |   |  | Baltimore City MD.   |  |
| 10. CITY OR TOWN OF DEATH   | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE) |  | 12b. KIND OF BUSINESS OR INDUSTRY                              |
| Baltimore   | South Balto Gen'l Hospital  |   | Supervisor   |  | Balto. County  |
| 13a. STATE  |   | 13b. COUNTY   | 13c. CITY OR TOWN  | 13d. INSIDE CITY LIMITS?   | 13e. STREET ADDRESS / ZIP CODE                                 |
| Maryland  |   | Balto Co.   | Baltimore  | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>            | 4109 Oak Road 21227  |
| 14. FATHER'S NAME   |   |   | 15. MOTHER'S MAIDEN NAME   |  |  |
| FIRST MIDDLE LAST<br>William Seifert  |   |   | FIRST MIDDLE LAST<br>Eva Pearl Disney                            |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)  |   | 16b. SOCIAL SECURITY NO.  | 17. INFORMANT ADDRESS  |  |  |
| Yes   |   | W.W. II 219.12.5560   | Peggy E. Seifert Wife Same as 13                                 |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Cardiac Arrest</b>   |   |   |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>1 hour</b>  |
| DUE TO, OR AS A CONSEQUENCE OF (b) <b>Diabetes-- Hypertension</b>   |   |   |  |  | <b>10 years</b>  |
| DUE TO, OR AS A CONSEQUENCE OF (c) <b>Coronary Artery Disease</b>   |   |   |  |  | <b>2 yrs</b>   |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: (a)  |   |   |  |  |  |
| 19a. DATE OF OPERATION  |   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  | 20a. AUTOPSY?  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? |
|   |   |   |  | YES <input type="checkbox"/> NO <input type="checkbox"/>                       | YES <input type="checkbox"/> NO <input type="checkbox"/>       |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |   | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK  |   | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                              |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>Dec 84</b> , 19 <b>50</b> , to <b>Dec 84</b> , 19 <b>84</b> , that (I) (we) lost<br>saw the deceased alive on <b>Dec 19</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated<br>above, (I) (we) (did) (did not) view the body after death. |   | 22b. SIGNATURE<br><b>Paul Schonfeld M.D.</b>  |  | 22c. DATE SIGNED<br><b>Jan. 29, 1985</b>                                       |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)   |   | 22e. ADDRESS  |  |  |  |
| Paul Schonfeld  |   | MD. 407 Crain Highway South, Glen Burnie, Md.   |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)  | 23b. DATE   | 23c. NAME OF CEMETERY OR CREMATORY  | 23d. LOCATION  |  |  |
| Burial  | Feb. 1, 1985  | Meadowridge Mem Park  | Elkridge Howard Md.  |  |  |
| 24. FUNERAL DIRECTOR<br>NAME ADDRESS  |   | 25a. DATE REC'D. BY REGISTRAR   |  | 25b. REGISTRAR'S SIGNATURE   |  |
| Singleton Funeral Home, Glen Burnie, Md.  |   | FEB 5 1985  |  | Linda Davidson-Randell   |  |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed with the death certificate with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

10 years  
2 yrs

Charles Andrew  
Nichols--Hyattsville  
Donnelly Army Detachment

10/10/1914

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 5 0 1 5 2 3

FOR  
1. STATE  
REGISTRAR

REG. NO.

|  |   |   |  |                                |   |
|--|---|---|--|--------------------------------|---|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>Slana M. Sellers  |   |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br>1 3 85                                |                                | 2b. HOUR<br>2:45 A  |
| 3. SEX<br>F  | 4. RACE<br>W  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>5 6 16  | 6. AGE (IN YEARS LAST BIRTHDAY)<br>68 YRS.                                   |                                | IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS.<br>HOURS MIN.                                |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>West Virginia   | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.A.  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Balt. City MD.                       |                                |   |
| 10. CITY OR TOWN OF DEATH<br>Balt.   | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>John L. Deaton Medical Ct. |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Waitress |                                | 12b. KIND OF BUSINESS OR INDUSTRY<br>White Coffee Pot   |
| 13a. STATE<br>Maryland   |   |   | 13b. COUNTY<br>---   | 13c. CITY OR TOWN<br>Baltimore | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>Randolph Hoover  |   |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Fronie White                |                                |   |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)<br>no |   | 16b. SOCIAL SECURITY NO.<br>235 20 1832   | 17. INFORMANT<br>Jesse G. Sellers  |                                |   |
|  |   | ADDRESS<br>1845 Ramsay St. 21223  |  |                                |   |

|   |  |   |
|---|--|---|
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I: DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Carcinoma of the lung bilaterally</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <u>S/P CVA</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____ |  | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH |
|---|--|---|

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)

|  |  |   |  |  |   |
|--|--|---|--|--|---|
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>      | 20b. IF YES, WERE FINDINGS USED<br>IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) |   |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                              |   |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>Aug 17</u> , 19 <u>85</u> , to <u>Jan 3</u> , 19 <u>85</u> , that (I) (we) last<br>saw the deceased alive on <u>Jan 3</u> , 19 <u>85</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated |  |   |  |  |   |
| 22b. SIGNATURE<br><u>Julian W. Reed</u>  |  | DEGREE<br>ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |  | 22c. DATE SIGNED   |   |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>JULIAN W. REED  |  | 22e. ADDRESS<br>611 S. CHAS. ST. BALTIMORE MD. 21201  |  |  |   |

|  |                          |   |   |
|--|--------------------------|---|---|
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br>Burial                         | 23b. DATE<br>Jan. 5 1985 | 23c. NAME OF CEMETERY OR CREMATORY<br>Holly Hill Cem. | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Baltimore Md. |
| 24. FUNERAL DIRECTOR<br>NAME ADDRESS<br>Lilly & Zeiler, Inc. 1901 Eastern Ave. |                          | 25a. DATE REC'D. BY REGISTRAR<br>JAN 7 1985           |   |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

UNITED STATES  
DEPARTMENT OF THE ARMY  
OFFICE OF THE CHIEF OF STAFF

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH   |  |   |  | REG. NO.<br>85 01524  |  |  |  |   |  |
|--|--|---|--|---|--|--|--|---|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>FIRST MIDDLE LAST<br>LACEY Shalynn SHACKELFORD  |  |   |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br>01 01 85   |  |  |  | 2b. HOUR<br>5:15PM  |  |
| 3. SEX<br>Female   |  | 4. RACE<br>White  |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>1/1/85  |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br>YRS MONTHS DAYS<br>8 45                           |  | IF UNDER 1 YEAR<br>IF UNDER 24 HRS<br>HOURS MIN.  |  |
| 7. BIRTHPLACE<br>(STATE OR FOREIGN COUNTRY)<br>West Virginia   |  | 7b. CITIZEN OF WHAT COUNTRY?<br>USA   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>BALTIMORE CITY MD.                           |  |   |  |
| 10. CITY OR TOWN OF DEATH<br>BALTIMORE   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>THE JOHNS HOPKINS HOSPITAL |  |   |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>None             |  | 12b. KIND OF BUSINESS OR INDUSTRY<br>None   |  |
| 13a. STATE<br>Maryland   |  |   |  | 13b. CITY OR TOWN<br>Knoxville  |  | 13c. STREET ADDRESS / ZIP CODE<br>4328 Burkittsville Road 21758                      |  |   |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>Anthony Wayne Shackelford  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Annette Lorraine Hackley   |  | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)<br>No  |  |  |  |   |  |
| 16b. SOCIAL SECURITY NO.<br>None   |  | 17. INFORMANT<br>ADDRESS<br>Anthony W. Shackelford - Knoxville, Md.   |  |   |  |  |  |   |  |
| 18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>RESPIRATORY ARREST</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <u>PULMONARY DYSGENESIS</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <u>RENAL AGENESIS</u>  |  |   |  |   |  |  |  | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH<br><u>IN UTERO</u><br><u>IN UTERO</u>   |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a   |  |   |  |   |  |  |  |   |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  |   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  | 20b. IF YES, WERE FINDINGS USED<br>IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)   |  |  |  |   |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |  |  |   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>1/1</u> , 19 <u>85</u> , to <u>1/1 5:15 PM</u> , 19 <u>85</u> , that (I) (we) lost<br>saw the deceased alive on <u>1/1</u> , 19 <u>85</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated<br>above (I) (we) (did) (did not) view the body after death. |  |   |  |   |  |  |  |   |  |
| 22b. SIGNATURE<br>Kenneth E. Bloom   |  |   |  | DEGREE<br>MD  |  |  |  | 22c. DATE SIGNED<br>1/1/85  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>KENNETH E. BLOOM, MD  |  |   |  | 22e. ADDRESS<br>JOHNS HOPKINS HOSP. N. WOLFE ST, BALTO, MD.   |  |  |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br>Burial   |  | 23b. DATE<br>1/4/85   |  | 23c. NAME OF CEMETERY OR CREMATORY<br>Brownsville Hgts. Cem.  |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Brownsville, Wash., Md.                |  |   |  |
| 24. FUNERAL DIRECTOR<br>NAME<br>John T. Williams   |  |   |  | 25a. DATE REC'D. BY REGISTRAR<br>7/1985   |  | 25b. REGISTRAR'S SIGNATURE<br>Julia Davidson-Rodgers                                 |  |   |  |

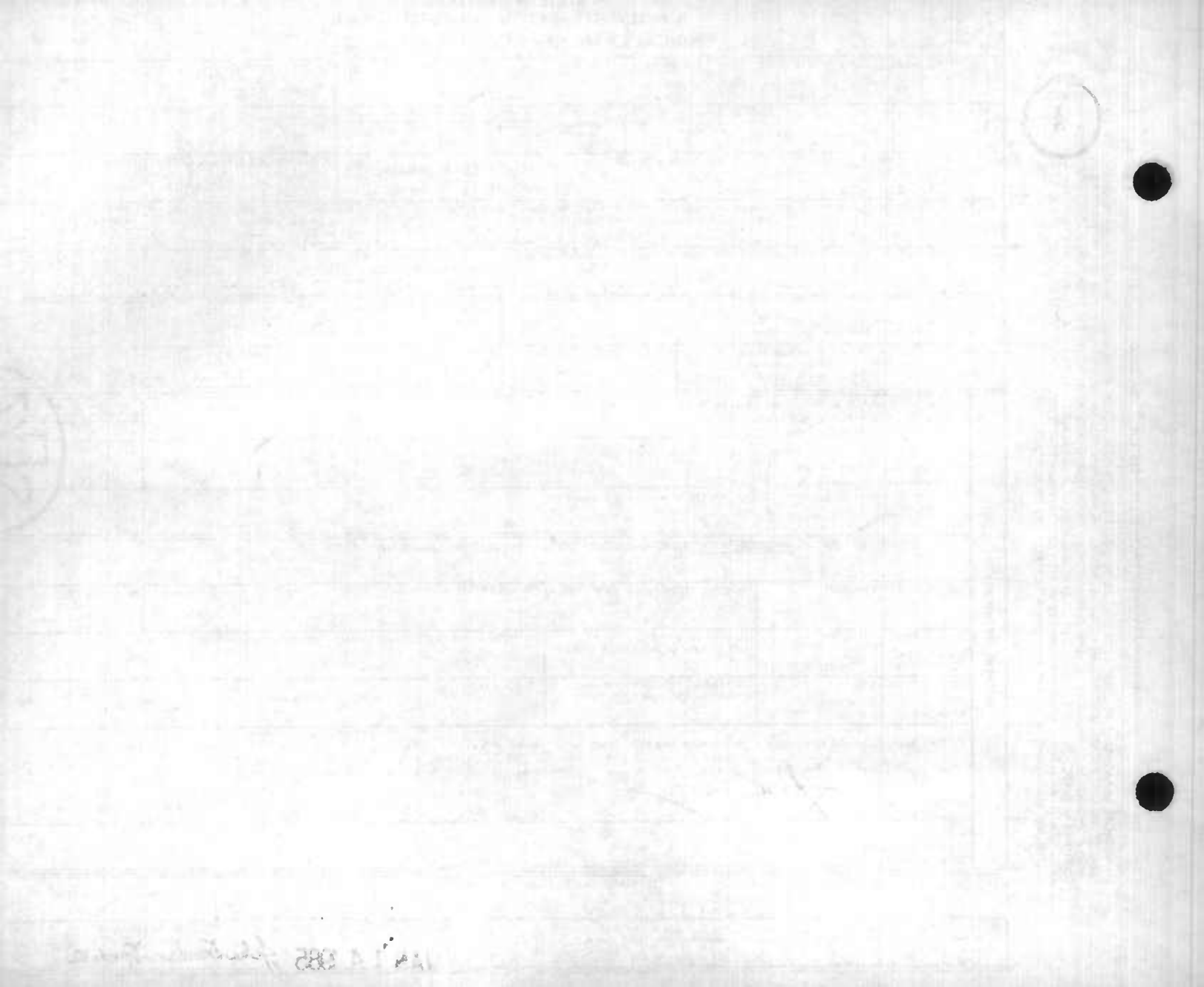




TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL HOME. GIVE PAGE 4 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR AFTER DEATH. WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP  
DHMH - 17  
(VR A15 ME (5))

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>MEDICAL EXAMINER'S CERTIFICATE OF DEATH  |                  |   |  |   |                               |  |  |  |  | REG. NO. 01525  |  |
|--|------------------|---|--|---|-------------------------------|--|--|--|--|---|--|
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST<br>Richard E. Shamleffer  |                  |   |  |   |                               |  |  |  |  | 20. DATE KNOWN OF DEATH ESTI. MATED <input checked="" type="checkbox"/> MONTH DAY YEAR HOUR<br>1/ 13/ 19 85 |  |
| 3. SEX<br>Male   | 4. RACE<br>Cauc. | 5. DATE OF BIRTH MONTH DAY YEAR<br>5/20/36  | 6. AGE (IN YEARS LAST BIRTHDAY)<br>48 YRS. | 7. IF UNDER 1 YR. MONTHS DAYS   | 8. IF UNDER 24 HRS. HOURS MIN | 21. DATE PRONOUNCED DEAD MONTH DAY YEAR<br>1/ 13/ 19 85                                      |  | 24. HOUR MIN<br>2:23 A M                         |  |   |  |
| 70. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Balto., Md.   |                  | 71. CITIZEN OF WHAT COUNTRY?<br>USA   |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |                               | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Baltimore City, MD.                                  |  |  |  |   |  |
| 10. CITY OR TOWN OF DEATH<br>Baltimore   |                  | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>3701 Elmora Ave. 21213 |  |   |                               | 120. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Engineer                    |  | 121. KIND OF BUSINESS<br>Electronic Module Corp. |  |   |  |
| USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)   |                  |   |  |   |                               |  |  |  |  |   |  |
| 130. STATE<br>Md.  |                  | 131. COUNTY<br>-  |  | 132. CITY OR TOWN<br>Balto.   |                               | 133. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 134. STREET ADDRESS<br>3701 Elmora Ave. 21213    |  |   |  |
| 14. FATHER'S NAME FIRST MIDDLE LAST<br>Edgar Shamleffer  |                  |   |  | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST<br>Elsie Lidinsky  |                               |  |  |  |  |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)<br>Yes  |                  | 16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES)<br>Peacetime   |  | 17. INFORMANT<br>Elizabeth Shamleffer, same address   |                               | ADDRESS  |  |  |  |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Arteriosclerotic Cardiovascular Disease</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____<br>PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: _____<br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |                  |   |  |   |                               |  |  |  |  |   |  |
| 19a. DATE OF OPERATION   |                  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?   |  |   |                               | 20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>             |  |  |  |   |  |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH  |                  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)   |                               |  |  |  |  |   |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>  |                  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)   |  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE  |                               |  |  |  |  |   |  |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: <u>Natural causes</u> <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>  |                  |   |  |   |                               |  |  |  |  |   |  |
| ACTUAL SIGNATURE <u>[Signature]</u>  |                  |   |  | TITLE (SPECIFY)<br>M.D. Assistant   |                               | MEDICAL EXAMINER   |  | DATE SIGNED 1/13/85                              |  |   |  |
| EXAMINER'S NAME (TYPE OR PRINT)<br>Gregory R. Kauffman, M.D.   |                  |   |  | ADDRESS<br>111 Penn St.   |                               |  |  |  |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br>Burial  |                  | 23b. DATE<br>1/16/85  |  | 23c. NAME OF CEMETERY OR CREMATORY<br>Holy Redeemer   |                               | 23d. LOCATION CITY OR TOWN COUNTY STATE<br>Balto., Md.                                       |  |  |  |   |  |
| 24. FUNERAL DIRECTOR<br>Schlunehk Funeral Home, Inc.<br>3331 Brehms Lane, Balto., Md. 21213  |                  |   |  | 25a. DATE REC'D. BY REGISTRAR<br>JAN 14 1985  |                               | 25b. REGISTRAR'S SIGNATURE<br>Julia Davidson-Randall   |  |  |  |   |  |



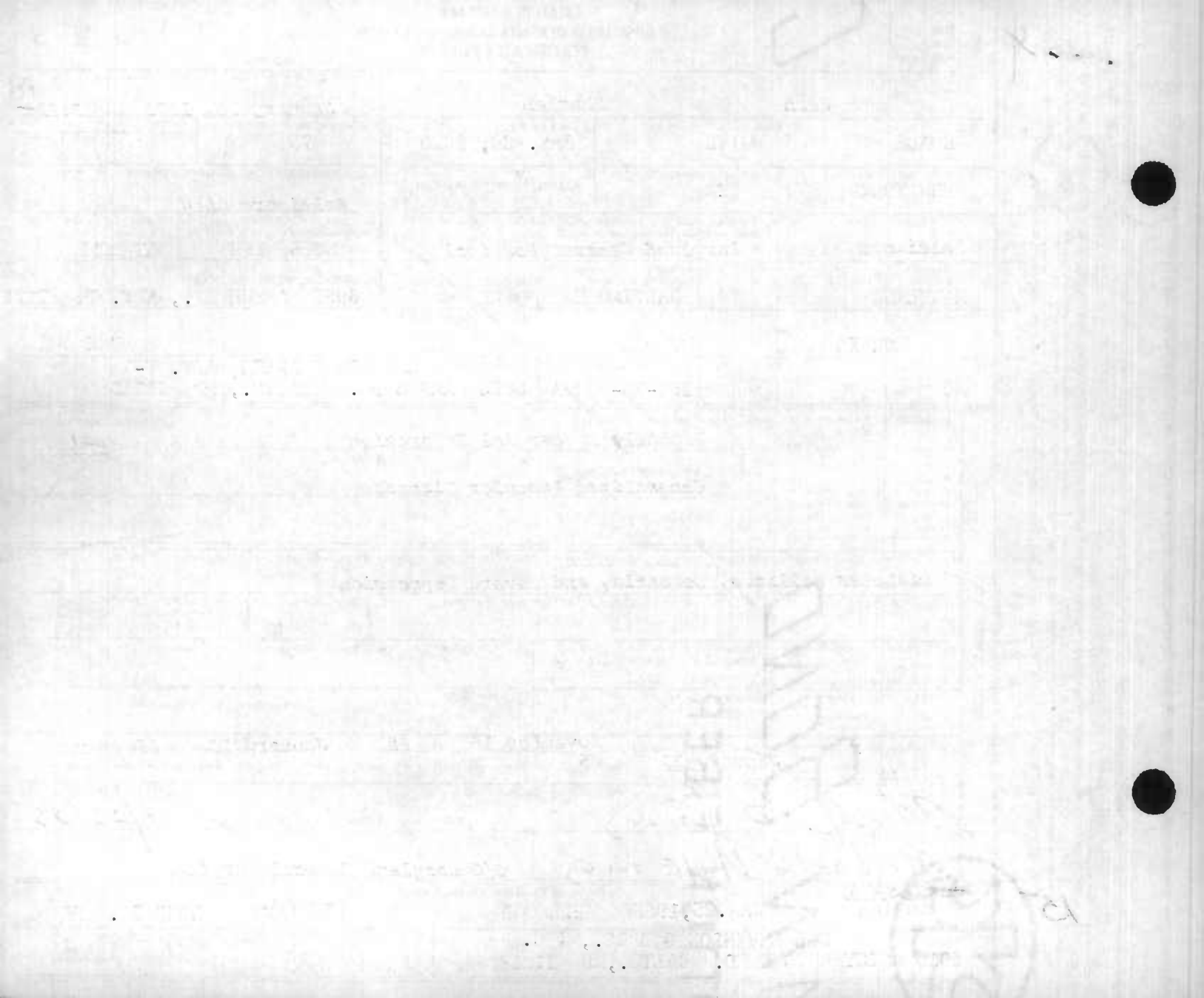
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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with 72 hours after the death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH  |  |  |  |   |  |   |  |  |  |
|---|--|--|--|---|--|---|--|--|--|
| 1. FOR STATE REGISTRAR  |  | REG. NO. 85 01526  |  |   |  |   |  |  |  |
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>Jean Sharken   |  |  |  |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br>January 23, 1985                              |   |  | 2b. HOUR<br>3:37 PM                          |  |
| 3. SEX<br>FEMALE  |  | 4. RACE<br>WHITE   |  | 5. DATE OF BIRTH<br>JAN. 20, 1910   |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br>75   |  | 7. IF UNDER 1 YEAR<br>MONTHS DAYS HOURS MIN. |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN)<br>NEW YORK   |  | 7b. CITIZEN OF WHAT COUNTRY?<br>USA  |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Baltimore City MD.                    |  |  |  |
| 10. CITY OR TOWN OF DEATH<br>Baltimore  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>Maryland General Hospital |  |   |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>HOUSEWIFE |  | 12b. KIND OF BUSINESS OR INDUSTRY<br>AT HOME |  |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE<br>MARYLAND  |  |  |  |   | 13c. CITY OR TOWN<br>BALTIMORE   |   | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                            |  |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>MORRIS HUMMEL   |  |  |  |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>SARAH UNKNOWN                       |   |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br>NO  |  | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br>152-28-5645A  |  | 17. INFORMANT<br>CHARLES SHARKEN APT. T-1<br>6938 MARSUE DR. BALTO., MD 21215   |  |   |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Probable Myocardial Infarction</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <u>Generalized Vascular Disease</u><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____<br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH   |  |  |  |   |  |   |  |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)<br><u>Diabetes Mellitus, Dementia, and Severe Depression</u>   |  |  |  |   |  |   |  |  |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |   | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1B, PART 1 OR PART 2)  |  |   |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |   |  |  |  |
| 22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <u>November 16</u> , 19 <u>84</u> , to <u>January 23</u> , 19 <u>85</u> , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on <u>January 23</u> , 19 <u>85</u> , and that in <input checked="" type="checkbox"/> (my) opinion death occurred on the date and hour and from the causes stated above. <input checked="" type="checkbox"/> (we) (did) (not) view the body after death. |  |  |  |   |  |   |  |  |  |
| 22b. SIGNATURE<br><u>Michael A. Hyle</u>  |  |  |  | DEGREE<br>ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>                   |  | 22c. DATE SIGNED<br><u>1/23/85</u>  |  |  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><u>Michael A. Hyle MD</u>  |  |  |  | 22e. ADDRESS<br><u>C/O Maryland General Hospital</u>  |  |   |  |  |  |
| 23a. MODE OF REMOVAL<br>(SPECIFY)<br>BURIAL   |  | 23b. DATE<br>JAN. 25, 1985   |  | 23c. NAME OF CEMETERY OR CREMATORY<br>WELLWOOD  |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>PINELAWN LONG IS. NY            |  |  |  |
| 24. FUNERAL DIRECTOR<br>SOL LEVINSON & BROS., INC.<br>6010 REISTERSTOWN RD. BALTO., MD 21215  |  |  |  | 25a. DATE REC'D. BY REGISTRAR<br>JAN 29 1985  |  | 25b. REGISTRAR'S SIGNATURE<br><u>Richard J. Gendall</u>                       |  |  |  |



STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8501527

REG. NO.

1. FOR  
STATE  
REGISTRAR

|   |  |   |  |   |  |  |   |  |   |  |
|---|--|---|--|---|--|--|---|--|---|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>JAMES L. SHEA  |  |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br>1 4 85                          |   |  | 2b. HOUR<br>1200 AM  |   |  |   |  |
| 3. SEX<br>MALE  |  | 4. RACE<br>BLACK  |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>04 19 1892  |  | 6. AGE (IN YEARS (LAST BIRTHDAY))<br>92 YRS  |   | 7. IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS<br>HOURS MIN.   |   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>JAMAICA  |  | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.A.  |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>CITY MD.                                     |   |  |   |  |
| 10. CITY OR TOWN OF DEATH<br>BALTIMORE  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>UNIVERSITY OF MARYLAND HOSP. |  |   |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>UNEMPLOYED       |   | 12b. KIND OF BUSINESS OR INDUSTRY  |   |  |
| 13a. STATE<br>STATEMD   |  |   | 13b. COUNTY<br>-   |   | 13c. CITY OR TOWN<br>BALTIMORE   |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 13e. STREET ADDRESS / ZIP CODE<br>1701 EUTAW PL., 21217 |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>UNKNOWN   |  |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>UNKNOWN               |   |  |  |   |  |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)  |  |   | 16b. SOCIAL SECURITY NO.<br>216-10-1253                                |   | 17. INFORMANT<br>ADDRESS<br>PARKER, DORIS 1108 ARLEMAUE<br>BALTIMORE, MD 21217 |  |   |  |   |  |
| 18. CAUSE OF DEATH: Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY.<br>IMMEDIATE CAUSE (a) <u>Profound Bradycardia E Resp. Arrest</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <u>presumed Sepsis</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <u>probable pneumonia</u><br>PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a<br><u>Clinical Metastatic cancer of Prostate; Chronic Renal Failure</u> |  |   |  |   |  |  |   | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH<br>45 min  |   |  |
|   |  |   |  |   |  |  |   | 3 hrs.   |   |  |
|   |  |   |  |   |  |  |   | 3 hrs.   |   |  |
|   |  |   |  |   |  |  |   |  |   |  |
| 19a. DATE OF OPERATION  |  |   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                       |   |  | 20a. AUTOPSY?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |   | 20b. IF YES, WERE FINDINGS USED<br>IN CERTIFYING CAUSES OF DEATH?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |   |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER NOTIFY MEDICAL EXAMINER)   |  |   | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19             |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) |  |   |  |   |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>   |  |   | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                              |  |   |  |   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>12-31-</u> 19 <u>84</u> to <u>1-4</u> 19 <u>85</u> , that (I) (we) last saw the deceased alive on <u>1-4</u> 19 <u>84</u> , and that in (my (our)) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.  |  |   |  |   |  |  |   |  |   |  |
| 22b. SIGNATURE<br>H. Richards MD  |  |   |  |   | DEGREE<br>MD   |  |   | 22c. DATE SIGNED   |   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>H. Richards MD   |  |   |  |   | 22e. ADDRESS<br>2250 Greene St.<br>Baltimore, Md 21209                         |  |   |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br>Burial  |  |   | 23b. DATE<br>1/7/85  |   | 23c. NAME OF CEMETERY OR CREMATORY<br>ARbutus mem                              |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>ARbutus Md  |  |   |  |
| 24. FUNERAL DIRECTOR<br>NAME<br>U.R. Bailey 1348 N. CALHOUN ST  |  |   |  |   | 25a. DATE REC'D. BY REGISTRAR<br>JAN 7 1985                                    |  |   |  |   |  |
|   |  |   |  |   | 25b. REGISTRAR'S SIGNATURE<br>John Davidson-Randall                            |  |   |  |   |  |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.





STATE OF MARYLAND  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 01528

|  |  |   |  |  |  |   |  |  |  |
|--|--|---|--|--|--|---|--|--|--|
| 1- FOR STATE REGISTRAR   |  | 2a. DATE KNOWN OF DEATH   |  | 2b. DATE ESTI. MATED   |  | 2c. DATE PRONOUNCED DEAD  |  | 2d. HOUR   |  |
| 1. DECEASED NAME (TYPE OR PRINT)   |  | 3. SEX  |  | 4. RACE  |  | 5. DATE OF BIRTH  |  | 6. AGE (IN YEARS LAST BIRTHDAY)  |  |
| LAWRENCE (LAMONT) SHERROD JR.  |  | Male  |  | Black  |  | 10 10 32  |  | 52 YRS.  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)  |  | 7b. CITIZEN OF WHAT COUNTRY?  |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH  |  | 10. CITY OR TOWN OF DEATH  |  |
| N. Carolina  |  | U.S.A.  |  |  |  | Baltimore City  |  | Baltimore  |  |
| 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION   |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)       |  | 12b. KIND OF BUSINESS OR INDUSTRY  |  | 13a. STATE  |  | 13b. COUNTY  |  |
| 6 S. Poppleton Street  |  |   |  |  |  | Maryland  |  |  |  |
| 13c. CITY OR TOWN  |  | 13d. INSIDE CITY LIMITS?  |  | 13e. STREET ADDRESS  |  | 14. FATHER'S NAME   |  | 15. MOTHER'S MAIDEN NAME   |  |
| Baltimore  |  | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 6 S. Poppleton Street 21223  |  | Lawrence  |  | Lottie Knight  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)                                     |  | 16b. SOCIAL SECURITY NO.  |  | 17. INFORMANT  |  | 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH   |  |
| NO   |  | 215-28-3717   |  | Thomas Sherrod   |  | Arteriosclerotic cardiovascular disease   |  |  |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?                   |  | 20. AUTOPSY?   |  | 21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH   |  | 21b. TIME OF INJURY  |  |
|  |  |   |  | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  |   |  | HOUR A.M. MONTH DAY YEAR   |  |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)         |  | 21f. LOCATION  |  | 22a. I certify that I took charge of the remains described above, held on   |  | Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion |  |
|  |  |   |  |  |  | death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> |  | TITLE (SPECIFY)  |  |
| ACTUAL SIGNATURE   |  | EXAMINER'S NAME (TYPE OR PRINT)                                     |  | ADDRESS  |  | DATE SIGNED   |  | M.D. ASSISTANT MEDICAL EXAMINER  |  |
| Margarita A. Korell, M.D.  |  | 111 Penn Street   |  | 1-14-85  |  | 23a. BURIAL, CREMATION, REMOVAL   |  | 23b. DATE  |  |
| BURIAL   |  | 1/18/85   |  | 23c. NAME OF CEMETERY OR CREMATORY   |  | 23d. LOCATION   |  | 23e. DATE REC'D. BY REGISTRAR  |  |
|  |  | Mount Calvary Cem.  |  | Anne Arundel Co., Md.  |  | JAN 17 1985   |  |  |  |
| 24. FUNERAL DIRECTOR   |  | 25. DATE REC'D. BY REGISTRAR  |  | 25a. REGISTRAR'S SIGNATURE   |  | 25b. REGISTRAR'S SIGNATURE  |  | 25c. REGISTRAR'S SIGNATURE   |  |
| Wm C March F/H Inc.  |  | 1101 E North Avenue   |  |  |  |   |  |  |  |

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, USE EXECUTE THE CERTIFICATE. WRITING THE WORD "PENDING" IN PENCIL IN ITEM 1B, GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.



1934-1935 COLLECTION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

FOR  
STATE  
REGISTRAR

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 5 0 1 5 2 9

REG. NO.

|   |  |  |  |   |   |  |   |  |                                   |  |  |
|---|--|--|--|---|---|--|---|--|-----------------------------------|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>FIRST MIDDLE LAST<br><b>RUSSELL ELDRIDGE SHROUT</b>  |  |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>01-06-85</b>                 |   | 2b. HOUR<br><b>9:10 A.M.</b>                                      |  |   |  |                                   |  |  |
| 3. SEX<br><b>MALE</b>   |  | 4. RACE<br><b>WHITE</b>  |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>2 28 10</b>  |   | 6. AGE (IN YEARS (LAST BIRTHDAY))<br><b>74</b> YRS.  |   | IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS.<br>HOURS MIN.   |                                   |  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>W. Virginia</b>   |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>  |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore City</b> MD.  |   |  |                                   |  |  |
| 10. CITY OR TOWN OF DEATH<br><b>Baltimore</b>   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>St. Agnes Hospital</b> |  |   |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Manager</b>   |   | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>Service Station</b>  |                                   |  |  |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE<br><b>Maryland</b>  |  |  | 13b. COUNTY<br><b>Baltimore</b>  |   | 13c. CITY OR TOWN<br><b>Baltimore</b>                             |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |                                   | 13e. STREET ADDRESS / ZIP CODE<br><b>3209 Georgetown Rd. 21230</b> |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Robert ShROUT</b>  |  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Grace Wilson</b>   |   |   |  |   |  |                                   |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>NO</b>   |  | 16b. SOCIAL SECURITY NO.<br><b>216-07-0973</b>   |  | 17. INFORMANT<br><b>Shirley C. ShROUT</b>   |   | ADDRESS <b>21230 3209 Georgetown Rd.</b>   |   |  |                                   |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Hyperkalemia &amp; Hypoglycemia</b><br>DUE TO, OR AS A CONSEQUENCE OF:<br>(b) <b>Renal failure &amp; Diabetic Induced</b><br>(c) <b>Diabetes mellitus, CHF</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. |  |  |  |   |   |  |   |  |                                   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>24 hours</b>    |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: (a)<br><b>Congestive Heart failure, S/P Myocardial Infarction</b>  |  |  |  |   |   |  |   |  |                                   |  |  |
| 19a. DATE OF OPERATION  |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                       |   |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |   | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |                                   |  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>19</b>           |   |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)   |   |  |                                   |  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> AT WORK<br>NO: WHILE <input type="checkbox"/> AT WORK  |  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) |   |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE  |   |  |                                   |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>1-2</b> , 19 <b>85</b> , to <b>1-6</b> , 19 <b>85</b> , that (I) (we) lost<br>saw the deceased alive on <b>1-6</b> , 19 <b>85</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated<br>above, (I) (we) (did) (did not) view the body after death.                               |  |  |  |   |   |  |   |  |                                   |  |  |
| 22b. SIGNATURE<br><b>P. Kanam</b>   |  |  | DEGREE<br><b>MD</b>  |   |   | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> |   |  | 22c. DATE SIGNED<br><b>1-6-85</b> |  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>KANAM</b>   |  |  | 22e. ADDRESS<br><b>St. Agnes Hospital, Baltimore, Md</b>               |   |   |  |   |  |                                   |  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>Burial</b>   |  |  | 23b. DATE<br><b>1/9/85</b>   |   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Loudon Park Cemetery</b> |  |   | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Baltimore Maryland</b>  |                                   |  |  |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>Hubbard Funeral Home, Inc.</b>   |  |  |  |   |   | ADDRESS<br><b>4107 Wilkens Ave.</b>  |   | 25a. DATE REC'D. BY REGISTRAR<br><b>JAN 7 1985</b>   |                                   | 25b. REGISTRAR'S SIGNATURE<br><b>Jana Davidson-Rendell</b>         |  |

BP

01-06-82-1-104

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TO HOSPITAL OR ATTENDING PHYSICIAN. The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH  |  |  |  |   |  |  |  |   |  | 8 5 0 1 5 3 0   |  |  |
|---|--|--|--|---|--|--|--|---|--|---|--|--|
| 1. FOR STATE REGISTRAR  |  |  |  |   | REG. NO.                                     |  |  |   |  |   |  |  |
| 1. DECEASED NAME (TYPE OR PRINT)<br>Lillian M Shugars   |  |  |  |   | 2a. DATE OF DEATH MONTH DAY YEAR<br>01-31-85 |  |  |   | 2b. HOUR<br>8:30A M  |   |  |  |
| 3. SEX<br>Female  |  | 4. RACE<br>Caucasian   |  | 5. DATE OF BIRTH MONTH DAY YEAR<br>8 5 02   |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br>82 YRS                                      |  | 7. IF UNDER 1 YEAR MONTHS DAYS  |  | 7. IF UNDER 24 HRS HOURS MIN.   |  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Maryland   |  | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.A.   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Baltimore City MD.                     |  |   |  |   |  |  |
| 10. CITY OR TOWN OF DEATH<br>Baltimore City   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>Bon Secours Hospital |  |   |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Housewife     |  | 12b. KIND OF BUSINESS OR INDUSTRY<br>Homemaker                                    |  |   |  |  |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE Maryland   |  |  |  |   | 13b. COUNTY                                  |  | 13c. CITY OR TOWN<br>Baltimore                               |   | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |   | 13e. STREET ADDRESS / ZIP CODE<br>1261 Carroll St. 21230 |  |
| 14. FATHER'S NAME FIRST MIDDLE LAST   |  |  |  |   | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST   |  |  |   |  |   |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No  |  |  |  |   | 16b. SOCIAL SECURITY NO.<br>215-10-6881      |  | 17. INFORMANT ADDRESS<br>Norman Ensey 1261 Carroll St. 21230 |   |  |   |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for 1a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) RESPIRATORY ARREST<br>DUE TO, OR AS A CONSEQUENCE OF (b) CONGESTIVE HEART FAILURE MONTHS<br>DUE TO, OR AS A CONSEQUENCE OF (c)  |  |  |  |   |  |  |  |   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH  |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 11a   |  |  |  |   |  |  |  |   |  |   |  |  |
| 19a. DATE OF OPERATION  |  |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  |  |  | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> |  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)   |  |  |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR<br>P.M. 19   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) |  |   |  |   |  |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>  |  |  |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE                                 |  |   |  |   |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from JULY 19 83 to JAN 31 19 85, that (I) (we) lost the deceased alive on JAN 30 19 85, and that in my (our) opinion death occurred on the date and hour and from the causes noted above; (I) (we) (did) (did not) view the body after death. |  |  |  |   |  |  |  |   |  |   |  |  |
| 22b. SIGNATURE<br>Winthrop C. Davis, MD   |  |  |  | DEGREE<br>ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>        |  |  |  | 22c. DATE SIGNED<br>1/31/85   |  |   |  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>Winthrop C. Davis  |  |  |  | 22e. ADDRESS<br>700 WASHINGTON BLVD, 21230  |  |  |  |   |  |   |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br>Burial   |  |  |  | 23b. DATE<br>2-4-85   |  | 23c. NAME OF CEMETERY OR CREMATORY<br>Meadowridge Park                         |  | 23d. LOCATION CITY OR TOWN COUNTY STATE<br>Elkridge Howard Md.                    |  |   |  |  |
| 24. FUNERAL DIRECTOR NAME<br>Raymond C. Fink Glen Burnie, Md. 21061   |  |  |  |   |  | 25. DATE REC'D. BY REGISTRAR<br>FEB 01 1985                                    |  | 25. REGISTRAR'S SIGNATURE<br>Davidson-Rodell                                      |  |   |  |  |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be returned by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove co-bon-papers. Pages 1 and 2 should be filed - item 72 - complete death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

## MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH   |  |  |  | 8 5 0 1 5 3 1  |  |  |  |
|--|--|--|--|--|--|--|--|
| 1. FOR STATE REGISTRAR   |  |  |  | REG. NO.   |  |  |  |
| 1. DECEASED NAME (TYPE OR PRINT)   |  |  |  | 2a. DATE OF DEATH  |  |  |  |
| FIRST MIDDLE LAST Stanley James Sidor, Jr.   |  |  |  | MONTH DAY YEAR January 25, 1985  |  |  |  |
| 3. SEX Male  |  |  |  | 7b. HOUR 3 P. M.   |  |  |  |
| 4. RACE White  |  |  |  | 5. DATE OF BIRTH   |  |  |  |
| MONTH DAY YEAR July 30 1917  |  |  |  | 6. AGE (IN YEARS LAST BIRTHDAY)  |  |  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland   |  |  |  | 7b. CITIZEN OF WHAT COUNTRY? U.S.A.  |  |  |  |
| 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>   |  |  |  | 9. BALTIMORE CITY OR COUNTY OF DEATH   |  |  |  |
| 10. CITY OR TOWN OF DEATH Baltimore  |  |  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Francis S. Key Medical Center |  |  |  |
| 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Welder   |  |  |  | 12b. KIND OF BUSINESS OR INDUSTRY General Motors   |  |  |  |
| 13a. STATE Maryland  |  |  |  | 13b. COUNTY Baltimore  |  |  |  |
| 13c. CITY OR TOWN Dundalk  |  |  |  | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  |  |  |
| 13e. STREET ADDRESS / ZIP CODE 7029 Dunbar Road 21222  |  |  |  |  |  |  |  |
| 14. FATHER'S NAME FIRST MIDDLE LAST Stanley J. Sidor, Sr.  |  |  |  | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Sophie Mucek  |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (IF YES, GIVE WAR OR DATES) Yes WW II   |  |  |  | 16b. SOCIAL SECURITY NO. 217-07-9108   |  |  |  |
| 17. INFORMANT ADDRESS  |  |  |  | Debbie Kahl 2805 Kirkleigh Road 21222  |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Coronary Occlusion   |  |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH   |  |  |  |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) H.A.S.C.V.D.  |  |  |  |  |  |  |  |
| (c) DUE TO, OR AS A CONSEQUENCE OF   |  |  |  |  |  |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a Chronic obstructive Pulmonary Disease   |  |  |  |  |  |  |  |
| 19a. DATE OF OPERATION   |  |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  |  |  |
| 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  |  |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  |  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)  |  |  |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19   |  |  |  |
| 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)  |  |  |  |  |  |  |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>   |  |  |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  |  |  |
| 21f. LOCATION STREET CITY OR TOWN COUNTY STATE   |  |  |  |  |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from Oct 10, 1970, to Jan. 25, 1985, that (I) saw the deceased alive on 1-24-85, and that in my opinion death occurred on the date and hour and from the causes stated above; (I) (did not) view the body after death. |  |  |  |  |  |  |  |
| 22b. SIGNATURE Benigno R. Lazaro M.D.  |  |  |  | 22c. DATE SIGNED 1-28-85   |  |  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) Dr. Benigno R. Lazaro  |  |  |  | 22e. ADDRESS 59 Dundalk Ave Balto Md 21222   |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial   |  |  |  | 23b. DATE 1/28/85  |  |  |  |
| 23c. NAME OF CEMETERY OR CREMATORY Holly Hill  |  |  |  | 23d. LOCATION CITY OR TOWN COUNTY STATE White Marsh Balto. Maryland  |  |  |  |
| 24. FUNERAL DIRECTOR NAME 7922 Wise Ave. Balto. MD 21222   |  |  |  | 25a. DATE REC'D. BY REGISTRAR FEB 1 1985   |  |  |  |
| Duda-Ruck Funeral Home of Dundalk, Inc.  |  |  |  | 25b. REGISTRAR'S SIGNATURE   |  |  |  |





RECEIVED

WALKER

Dr. J. C. ...  
WALKER

Chemical ...

1-24-82

1-24-82

W. J. ...

Dr. J. C. ...

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, fill medical certifier box. See instructions on the back of this certificate.

## MEDICAL CERTIFICATION

| FOR STATE REGISTRAR  |  |  |  | STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE   |  | 8 5 0 1 5 3 2  |  |
|--|--|--|--|--|--|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)  |  |  |  | 2a. DATE OF DEATH  |  | 2b. HOUR   |  |
| FIRST MIDDLE LAST<br><b>Mary SIMMONS</b>   |  |  |  | MONTH DAY YEAR<br><b>January 30, 1985</b>  |  | HOUR MIN.<br><b>3:30A</b>                                      |  |
| 3 SEX  |  | 4 RACE   |  | 5. DATE OF BIRTH   |  | 6. AGE (IN YEARS LAST BIRTHDAY)                                |  |
| <b>Female</b>  |  | <b>Cauc.</b>   |  | MONTH DAY YEAR<br><b>7 16 1891</b>   |  | YRS. MONTHS DAYS HOURS MIN.<br><b>93</b>                       |  |
| 7a BIRTHPLACE (STATE OR FOREIGN COUNTRY)   |  | 7b CITIZEN OF WHAT COUNTRY?  |  | 8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH                           |  |
| <b>Md.</b>   |  | <b>U.S.A.</b>  |  |  |  | <b>Baltimore City MD.</b>                                      |  |
| 10. CITY OR TOWN OF DEATH  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN A FACILITY, GIVE STREET ADDRESS) |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)   |  | 12b. KIND OF BUSINESS OR INDUSTRY                              |  |
| <b>Baltimore</b>   |  | <b>Maryland General Hospital</b>   |  | <b>Housewife</b>   |  |  |  |
| 13a. STATE   |  |  |  | 13b. CITY OR TOWN  |  | 13c. STREET ADDRESS / ZIP CODE                                 |  |
| <b>Md.</b>   |  |  |  | <b>Baltimore</b>   |  | <b>7224 Gough St. 71224</b>                                    |  |
| 14. FATHER'S NAME  |  |  |  | 15. MOTHER'S MAIDEN NAME   |  |  |  |
| FIRST MIDDLE LAST<br><b>Michael Polarski</b>   |  |  |  | FIRST MIDDLE LAST<br><b>Stanislawa Polyczynski</b>   |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)   |  |  |  | 16b. SOCIAL SECURITY NO.   |  | 17. INFORMANT ADDRESS  |  |
| <b>No</b>  |  |  |  | <b>213-74-8883</b>   |  | <b>Margaret Zahner 7224 Gough St.</b>                          |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY.<br>IMMEDIATE CAUSE (a) <b>Congestive heart failure</b><br>DUE TO, OR AS A CONSEQUENCE OF (b) _____<br>DUE TO, OR AS A CONSEQUENCE OF (c) _____   |  |  |  |  |  |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: (a) <b>Osteomyelitis of the left hip.</b>   |  |  |  |  |  |  |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  | 20a. AUTOPSY?  |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? |  |
| <b>January 12, 1985</b>  |  | <b>Osteoporosis of the left Hip</b>  |  | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  | YES <input type="checkbox"/> NO <input type="checkbox"/>       |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)   |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK   |  | 21e. PLACE OF INJURY<br>(AT HOME STREET, FACTORY, OFFICE, FARM, ETC.)                                  |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE  |  |  |  |
| 22. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <b>January 7</b> 19 <b>85</b> , to <b>January 30</b> 19 <b>85</b> , that <input checked="" type="checkbox"/> we last saw the deceased alive on <b>January 7</b> 19 <b>85</b> , and that in <input checked="" type="checkbox"/> (our) opinion death occurred on the date and hour and from the causes stated above. <input checked="" type="checkbox"/> (we) did <input checked="" type="checkbox"/> did not view the body after death. |  |  |  |  |  |  |  |
| 22b. SIGNATURE   |  |  |  | DEGREE   |  | 22c. DATE SIGNED   |  |
| <b>Maimoona Shaukat, M.D.</b>  |  |  |  | <b>M.D.</b>  |  | <b>1/30/85</b>   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)  |  |  |  | 22e. ADDRESS   |  |  |  |
| <b>Maimoona Shaukat, M.D.</b>  |  |  |  | <b>c/o Msryland General Hospital</b>   |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)   |  | 23b. DATE  |  | 23c. NAME OF CEMETERY OR CREMATORY   |  | 23d. LOCATION<br>CITY OR TOWN                                  |  |
| <b>Burial</b>  |  | <b>2/4/85</b>  |  | <b>Baltimore National</b>  |  | <b>Baltimore</b>   |  |
| 24. FUNERAL DIRECTOR<br>NAME   |  |  |  | 25a. DATE RECEIVED BY  |  |  |  |
| <b>B. Dabrowski &amp; Son 2818 E. Baltimore St.</b>  |  |  |  | <b>Feb 1 1985</b>  |  |  |  |



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U.S.A. X

Hodgswile

Belmonte, William X 1924-1925

Belmonte, William X 1924-1925

Belmonte, William X 1924-1925

1924-1925



Belmonte, William X 1924-1925

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. GIVE PAGE 4 TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>MEDICAL EXAMINER'S CERTIFICATE OF DEATH   |  |                         |  |   |  |   |   |   |   | REG. NO. 5 0 1 5 3 3  |  |
|---|--|-------------------------|--|---|--|---|---|---|---|---|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT) FIRST MIDDLE LAST<br><b>ELIZABETH H. SIMMS</b>  |  |                         |  |   |  |   | 2a. DATE KNOWN OF DEATH<br>MONTH DAY YEAR<br><b>1 31 19 85</b>                                  |   | 2b. HOUR<br>M<br><b>4:25 PM</b>                                   |   |  |
| 3. SEX<br><b>Female</b>   |  | 4. RACE<br><b>Black</b> |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>4 11 01</b>              |  | 6. AGE (IN YEARS)<br>LAST BIRTHDAY YRS.<br><b>83</b>  |   | IF UNDER 1 YR.<br>MONTHS DAYS<br><b>0 0</b>                         |   | IF UNDER 24 HRS.<br>HOURS MIN.<br><b>0 0</b>  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Maryland</b>  |  |                         | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>  |   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |   |   | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore City</b> MD. |   |  |
| 10. CITY OR TOWN OF DEATH<br><b>Baltimore</b>   |  |                         | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>1811 W. Lombard St.</b> |   |  |   | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)                                   |   |   | 12b. KIND OF BUSINESS OR INDUSTRY   |  |
| 13a. STATE<br><b>Maryland</b>   |  |                         | 13b. COUNTY  |   | 13c. CITY OR TOWN<br><b>Baltimore</b>                            |   | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |   | 13e. STREET ADDRESS<br><b>1811 W. Lombard St. 21223</b>           |   |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Wesley Johnson</b>   |  |                         |  |   |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Shopia Harwood</b>  |   |   |   |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO, OR UNKNOWN)<br><b>Unknown</b>   |  |                         | 16b. SOCIAL SECURITY NO.<br><b>220-16-4868</b>   |   |  | 17. INFORMANT ADDRESS<br><b>Joyce McJamerson 1811 W. Lombard St</b>   |   |   |   |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1 DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Congestive heart failure</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost.<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____  |  |                         |  |   |  |   |   |   |   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH  |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1  |  |                         |  |   |  |   |   |   |   |   |  |
| 19a. DATE OF OPERATION  |  |                         |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?                 |  |   |   |   |   | 20. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |
| 21a. EXTERNAL CAUSE WAS<br>UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH  |  |                         |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b> |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)   |   |   |   |   |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>   |  |                         |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)       |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |   |   |   |   |  |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> . |  |                         |  |   |  |   |   |   |   |   |  |
| ACTUAL SIGNATURE<br><i>Ann M. Dixon</i>   |  |                         |  | TITLE (SPECIFY)<br>M.D. <b>Assistant</b> MEDICAL EXAMINER         |  |   |   | DATE SIGNED <b>2-1-85</b>   |   |   |  |
| EXAMINER'S NAME (TYPE OR PRINT)<br><b>Ann M. Dixon, M.D.</b>  |  |                         |  | ADDRESS <b>111 Penn St., Balto., Md. 21201</b>                    |  |   |   |   |   |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>Burial</b>  |  |                         | 23b. DATE<br><b>2/6/85</b>   |   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Mount Zion Cemetery</b> |   |   | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Lansdowne, Md.</b> |   |   |  |
| 24. FUNERAL DIRECTOR<br>NAME ADDRESS<br><b>Wm C March F/H Inc. 1101 E North Avenue</b>  |  |                         |  |   |  | 25a. DATE REC'D. BY REGISTRAR<br><b>FEB 4 1985</b>  |   | 25b. REGISTRAR'S SIGNATURE<br><i>Juha Davidson-Randall</i>          |   |   |  |

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DOWN

WINTER



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.  
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 5 0 1 5 3 4

1- FOR  
STATE  
REGISTRAR

REG. NO.

|   |  |   |   |   |   |  |  |  |  |
|---|--|---|---|---|---|--|--|--|--|
| 1 DECEASED NAME<br>(TYPE OR PRINT)<br><b>IRENE SIMMS</b>  |  |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>JANUARY 6, 1985</b>                               |   |   | 2b. HOUR<br><b>7:40A</b> M   |  |  |  |
| 3 SEX<br><b>Female</b>  |  | 4 RACE<br><b>Black</b>  |   | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>6 11 1892</b>  |   | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>92</b> YRS.  |  | IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS.<br>HOURS MIN.   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Maryland</b>  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U. S. A.</b>   |   | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore</b> MD.   |  |  |  |
| 10. CITY OR TOWN OF DEATH<br><b>Baltimore</b>   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Church Hospital X Corp.</b> |   |   |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Domestic</b>  |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>Pvt. Family</b>  |  |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)   |  |   |   |   | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |  |  |  |
| 13a. STATE<br><b>Maryland</b>   |  | 13b. COUNTY   |   | 13c. CITY OR TOWN<br><b>Baltimore</b>   |   | 13e. STREET ADDRESS / ZIP CODE<br><b>501 W. Franklin St. Baltimore, Maryland 21201</b>   |  |  |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Unknown Unknown Unknown</b>  |  |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Unknown Unknown Unknown</b>             |   |   |  |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>No.</b>  |  | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br><b>219-30-9070A</b>  |   | 17. INFORMANT<br><b>Mary Bevans</b>   |   | ADDRESS<br><b>3814 Copley Road Baltimore, Maryland 21215</b>   |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>CARDIOPULMONARY ARREST</b>   |  |   |   |   |   |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>10 Minutes</b>  |  |
| DUE TO, OR AS A CONSEQUENCE OF<br>(b) <b>WORSENING RENAL FAILURE WITH ANASARCA AND ELECTROLYTE BALANCE</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <b>DEHYDRATION AND PNEUMONIA</b>  |  |   |   |   |   |  |  | <b>2 WEEKS</b>   |  |
|   |  |   |   |   |   |  |  | <b>2 weeks</b>   |  |
|   |  |   |   |   |   |  |  |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <b>10</b>  |  |   |   |   |   |  |  |  |  |
| 19a. DATE OF OPERATION  |  |   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |   |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  |   | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19                                  |   |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)   |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> AT WORK<br>NOT WHILE <input type="checkbox"/> AT WORK  |  |   | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                      |   |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE  |  |  |  |
| 22a. I certify that (I) this hospital attended the deceased from <b>DECEMBER 26, 1984</b> , to <b>JANUARY 6, 1985</b> , that (I) <input checked="" type="checkbox"/> we last saw the deceased alive on <b>JANUARY 6, 1985</b> , and that in (my) <input checked="" type="checkbox"/> our opinion death occurred on the date and hour and from the causes stated above, (I) <input checked="" type="checkbox"/> (we) <input type="checkbox"/> did not view the body after death. |  |   |   |   |   |  |  |  |  |
| 22b. SIGNATURE<br><b>Carol S. Ramsey</b>  |  |   | DEGREE<br><b>D.O.</b>   |   |   | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> |  | 22c. DATE SIGNED<br><b>1/6/85</b>  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>CAROL S. RAMSEY</b>   |  |   | 22e. ADDRESS<br><b>CHURCH HOSPITAL CORPORATION<br/>100 N. BROADWAY, BALTIMORE, MD 21231</b> |   |   |  |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>Burial</b>  |  |   | 23b. DATE<br><b>1/10/85</b>   |   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Mt. Auburn Cemetery</b>                                |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Baltimore, Maryland</b> |  |  |
| 24. NAME OF FUNERAL HOME<br><b>Nutter &amp; Sons</b>  |  |   |   |   | 25a. DATE REC'D. BY REGISTRAR<br><b>JAN 9 1985</b>  |  | 25b. REGISTRAR'S SIGNATURE<br><b>Lia Davidson-Randall</b>                |  |  |
| 24. ADDRESS OF FUNERAL HOME<br><b>Funeral Home Inc. Baltimore, Md. 21216</b>  |  |   |   |   |   |  |  |  |  |

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STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 5 0 1 5 3 5

FOR  
1 - STATE  
REGISTRAR

REG. NO.

|  |  |   |   |  |   |
|--|--|---|---|--|---|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>FIRST MIDDLE LAST<br><b>MARGARET C. SIMON</b>   |  |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>1 18 85</b>   |  | 2b. HOUR<br>MIN.<br><b>6:05</b>                   |
| 3. SEX<br><b>FEMALE</b>  | 4. RACE<br><b>White</b>  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>June 14, 1921</b>  |   | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>63</b> YRS.                                    |   |
| 7a. BIRTHPLACE<br>(STATE OR FOREIGN)<br><b>Maryland</b>  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>   | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore City</b> MD.                    |   |
| 10. CITY OR TOWN OF DEATH<br><b>Baltimore</b>  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>St. Agnes Hospital, Balto. Md.</b> |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Housewife</b>            |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>21225</b> |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13b. STATE<br><b>Maryland</b>  |  | 13c. CITY OR TOWN<br><b>Brooklyn Park</b>   | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 13e. STREET ADDRESS, ZIP CODE<br><b>746 Old Riverside Rd. Balto. Md.</b>             |   |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Frank Schatt</b>  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Margaret Oberlei</b>  |   |  |   |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>No</b>  |  | 16b. SOCIAL SECURITY NO.<br><b>219-07-2130</b>  |   | 17. INFORMANT<br>ADDRESS<br><b>Mr. Fred J. Simon, Same as # 13</b>                   |   |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>cardiopulmonary arrest</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <b>Septic shock</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <b>squamous cell ca of RUL &amp; brain metas.</b>   |  |   |   |  | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH   |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a   |  |   |   |  |   |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |   |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)        |   |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                    |   |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>1-18</b> , 19 <b>85</b> , to <b>1-18</b> , 19 <b>85</b> , that (I) (we) last saw the deceased alive on <b>1-18</b> , 19 <b>85</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |  |   |   |  |   |
| 22b. SIGNATURE<br><b>S. SNAMEO</b>   |  | DEGREE  |   | 22c. DATE SIGNED<br><b>1-18-85</b>   |   |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>EDNA S YEO</b>   |  | 22e. ADDRESS<br><b>ST AGNES HOSPITAL</b>  |   |  |   |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>Burial</b>  | 23b. DATE<br><b>Jan. 22, 1985</b>  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Holy Cross Cemetery</b>  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Baltimore, Maryland</b>                        |  |   |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>McCall Funeral Home 237 E. Patapsco Ave. Balto.</b>   |  |   | 25a. DATE REC'D. BY REGISTRAR<br><b>JAN 21 1985</b>   |  |   |
| 25b. REGISTRAR'S SIGNATURE<br><i>[Signature]</i>   |  |   |   |  |   |

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 4 should be detached for use at the burial/transit permit. Then please return carbon papers. Pages 1 and 2 should be filed with the Registrar, with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, removal of the body must be reported to the State Dept. of Health and Mental Hygiene.

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**STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH**

8 5 0 1 5 3 6

**1. FOR  
STATE  
REGISTRAR**

REG. NO.

|  |   |   |   |  |  |
|--|---|---|---|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>Eula B. Simpson   |   |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br>Jan. 13, 1985  |  | 2b. HOUR<br>5:25 AM  |
| 3. SEX<br>Female   | 4. RACE<br>Negro  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>1-29-17   | 6. AGE (IN YEARS LAST BIRTHDAY)<br>67 YRS.  | IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS.<br>HOURS MIN.                     |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Delaware  | 7b. CITIZEN OF WHAT COUNTRY?<br>USA   | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Baltimore City MD.                                      |  |  |
| 10. CITY OR TOWN OF DEATH<br>Baltimore City  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>Mercy Hospital |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Homemaker                   | 12b. KIND OF BUSINESS OR INDUSTRY  |  |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE<br>MD   | 13b. COUNTY   | 13c. CITY OR TOWN<br>Baltimore  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | 13e. STREET ADDRESS<br>2625 Grogan Ave. 21213  |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>Elmo Dean  |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Marie Matthews   |   |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br>Unknown  | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br>214169425  |   | 17. INFORMANT<br>ADDRESS<br>Bernice Dean 2625 Grogan Avenue                                     |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Metastatic Lung CANCER</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____<br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><u>2 years</u> |   |   |   |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <u>NO</u>   |   |   |   |  |  |
| 19a. DATE OF OPERATION   |   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |   | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)       |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  |   | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                    |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>NOVEMBER 19, 1984</u> to <u>JANUARY 13, 1985</u> , that (I) (we) <u>did</u> <u>not</u> saw the deceased alive on <u>JANUARY 13, 1985</u> , and that in <u>my</u> (our) opinion death occurred on the date and hour and from the causes stated above. (If we) (did) (did not) view the body after death.  |   |   |   |  |  |
| 22b. SIGNATURE<br><u>Christine P Bell-Lafferman</u> M.D. ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>  |   |   |   | 22c. DATE SIGNED<br><u>1/13/85</u>   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><u>CHRISTINE LATTEERMAN MD</u>  |   |   |   | 22e. ADDRESS<br><u>MERCY HOSPITAL BALTIMORE MARYLAND</u>                             |  |
| 23a. BURIAL, CREMATION, REMOVAL<br><u>BURIAL</u>   | 23b. DATE<br><u>1/19/85</u>   | 23c. NAME OF CEMETERY OR CREMATORY<br><u>Baltimore Cemetery</u>   | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><u>Baltimore, Md.</u>                             |  |  |
| 24. FUNERAL DIRECTOR<br>NAME<br><u>Wm C March F/H Inc. 1101 E North Avenue</u>   |   |   | 25a. DATE REC'D. BY REGISTRAR<br><u>JAN 17 1985</u>   | 25b. REGISTRAR'S SIGNATURE<br><u>Gina Davidson-Randall</u>                           |  |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 1 and 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.  
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 1 and 2 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8501537

FOR  
STATE  
REGISTRAR

REG. NO.

|  |   |   |   |  |  |
|--|---|---|---|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>Georgenar B. Singleton  |   |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br>January 18, 1985   |  | 2b. HOUR<br>M  |
| 3. SEX<br>Female   | 4. RACE<br>Black  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>3 22 01   |   | 6. AGE (IN YEARS LAST BIRTHDAY)<br>83<br>YRS                                   | IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS.<br>HOURS MIN.   |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>S.C.  | 7b. CITIZEN OF WHAT COUNTRY?<br>USA   | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Baltimore City MD.                     |  |
| 10. CITY OR TOWN OF DEATH<br>Baltimore   | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>1401 Lakewood Avenue |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)                                | 12b. KIND OF BUSINESS OR INDUSTRY  |  |
| 13a. STATE<br>MD   | 13b. COUNTY   | 13c. CITY OR TOWN<br>Baltimore  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | 13. STREET ADDRESS / ZIP CODE<br>1401 Lakewood Ave. 21213                      |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>George Broom   |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Carrie   |   |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)<br>No   |   | 16b. SOCIAL SECURITY NO.<br>251-42-3225   |   | 17. INFORMANT<br>ADDRESS<br>B Evelyn McGill 1401 Lakewood Avenue               |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Cardiac Failure</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(b) <u>CVA x 2</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____<br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |   |   |   |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <u>Elevated Blood Pressure</u>   |   |   |   |  |  |
| 19a. DATE OF OPERATION   |   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>      | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |   | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  |   | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                              |  |
| 22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) lost<br>saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated<br>above, (I) (we) (did) (did not) view the body after death.  |   |   |   |  |  |
| 22b. SIGNATURE<br><u>Adrian G. Dixon</u>   |   | DEGREE<br>MD  |   | 22c. DATE SIGNED<br>1/21/85  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>ADRIAN G. DIXON   |   | 22e. ADDRESS<br>1501 DIVISION ST<br>BALTIMORE MD 21217  |   |  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br>Burial   | 23b. DATE<br>1/24/85  | 23c. NAME OF CEMETERY OR CREMATORY<br>Church Cem.   |   | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Winnsboro S.C.                   |  |
| 24. FUNERAL DIRECTOR<br>NAME<br>Wm. C. March F/H 1101 E. North Ave.  |   |   | 25a. DATE REC'D. BY REGISTRAR<br>JAN 22 1985  |  |  |
|  |   |   | 25b. REGISTRAR'S SIGNATURE<br><u>Wm. C. March</u>   |  |  |

BP.

7

James A. [unclear]  
[unclear]

[unclear]

James A. [unclear]  
[unclear]

[unclear]



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 48 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

## MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>MEDICAL EXAMINER'S CERTIFICATE OF DEATH   |  |                  |  |  |  |  |  |   |  | REG. NO. 5 0 1 5 3 8                              |  |               |  |
|---|--|------------------|--|--|--|--|--|---|--|---|--|---------------|--|
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST<br>JEFFREY A. SIRETT   |  |                  |  |  |  |  |  |   |  | 2a. DATE KNOWN OF DEATH MONTH DAY YEAR<br>1-14-85 |  | 2b. HOUR<br>M |  |
| 3. SEX<br>MALE  |  | 4. RACE<br>WHITE |  | 5. DATE OF BIRTH MONTH DAY YEAR<br>SEPT. 29, 1931            |  | 6. AGE (IN YEARS LAST BIRTHDAY) MONTHS DAYS HOURS MIN<br>53 YRS. |  | 7c. DATE PRONOUNCED DEAD MONTH DAY YEAR<br>1-14-85  |  | 2d. HOUR<br>5:10A M                               |  |               |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>England  |  |                  |  | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.A.                       |  |  |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>   |  |   |  |               |  |
| 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Baltimore City  |  |                  |  | 10. CITY OR TOWN OF DEATH<br>Baltimore                       |  |  |  | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>3700 Ednor Rd.   |  |   |  |               |  |
| 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br>SELF-EMP.  |  |                  |  | 12b. KIND OF BUSINESS OR INDUSTRY<br>TAILOR CO.              |  |  |  | 13a. STREET ADDRESS<br>3700 EDNOR ROAD  |  |   |  |               |  |
| 13a. STATE<br>Maryland  |  |                  |  | 13b. COUNTY  |  |  |  | 13c. CITY OR TOWN<br>BALTIMORE  |  |   |  |               |  |
| 14. FATHER'S NAME FIRST MIDDLE LAST<br>GEORGE A. SIRETT   |  |                  |  | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST<br>JESSIE A. FILL |  |  |  | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) (IF YES, GIVE WAR OR DATES)<br>NO  |  |   |  |               |  |
| 16b. SOCIAL SECURITY NO.<br>212 309598  |  |                  |  | 17. INFORMANT<br>Family Records                              |  |  |  | 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Arteriosclerotic cardiovascular disease</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____<br>Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. |  |   |  |               |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).   |  |                  |  |  |  |  |  |   |  |   |  |               |  |
| 19a. DATE OF OPERATION  |  |                  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?            |  |  |  | 20. AUTOPSY?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>   |  |   |  |               |  |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH   |  |                  |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR<br>P.M. 19      |  |  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)   |  |   |  |               |  |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  |  |                  |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)  |  |  |  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE  |  |   |  |               |  |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: <u>Natural causes</u> <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> . |  |                  |  |  |  |  |  |   |  |   |  |               |  |
| ACTUAL SIGNATURE<br>Margarita A. Korell   |  |                  |  | TITLE (SPECIFY)<br>Assistant                                 |  |  |  | DATE<br>1-14-85   |  |   |  |               |  |
| EXAMINER'S NAME (TYPE OR PRINT)<br>Margarita A. Korell, M.D.  |  |                  |  | ADDRESS<br>111 Penn Street                                   |  |  |  | MEDICAL EXAMINER<br>SIGNED  |  |   |  |               |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br>CREMATION  |  |                  |  | 23b. DATE<br>Jan. 15, 1985                                   |  |  |  | 23c. NAME OF CEMETERY OR CREMATORY<br>GREEN MOUNT CEM.  |  |   |  |               |  |
| 23d. LOCATION CITY OR TOWN<br>BALT. MORE  |  |                  |  | COUNTY<br>MARYLAND   |  |  |  | STATE   |  |   |  |               |  |
| 24. FUNERAL DIRECTOR NAME<br>EVANS CHAPEL OF MEMORIES   |  |                  |  | ADDRESS<br>8800 HARFORD ROAD                                 |  |  |  | 25a. DATE REC'D. BY REGISTRAR<br>JAN 16 1985  |  |   |  |               |  |
| 25b. REGISTRAR'S SIGNATURE<br>William D. ...  |  |                  |  |  |  |  |  |   |  |   |  |               |  |



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WINTER



STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 5 0 1 5 3 9

1. FOR  
STATE  
REGISTRAR

REG. NO.

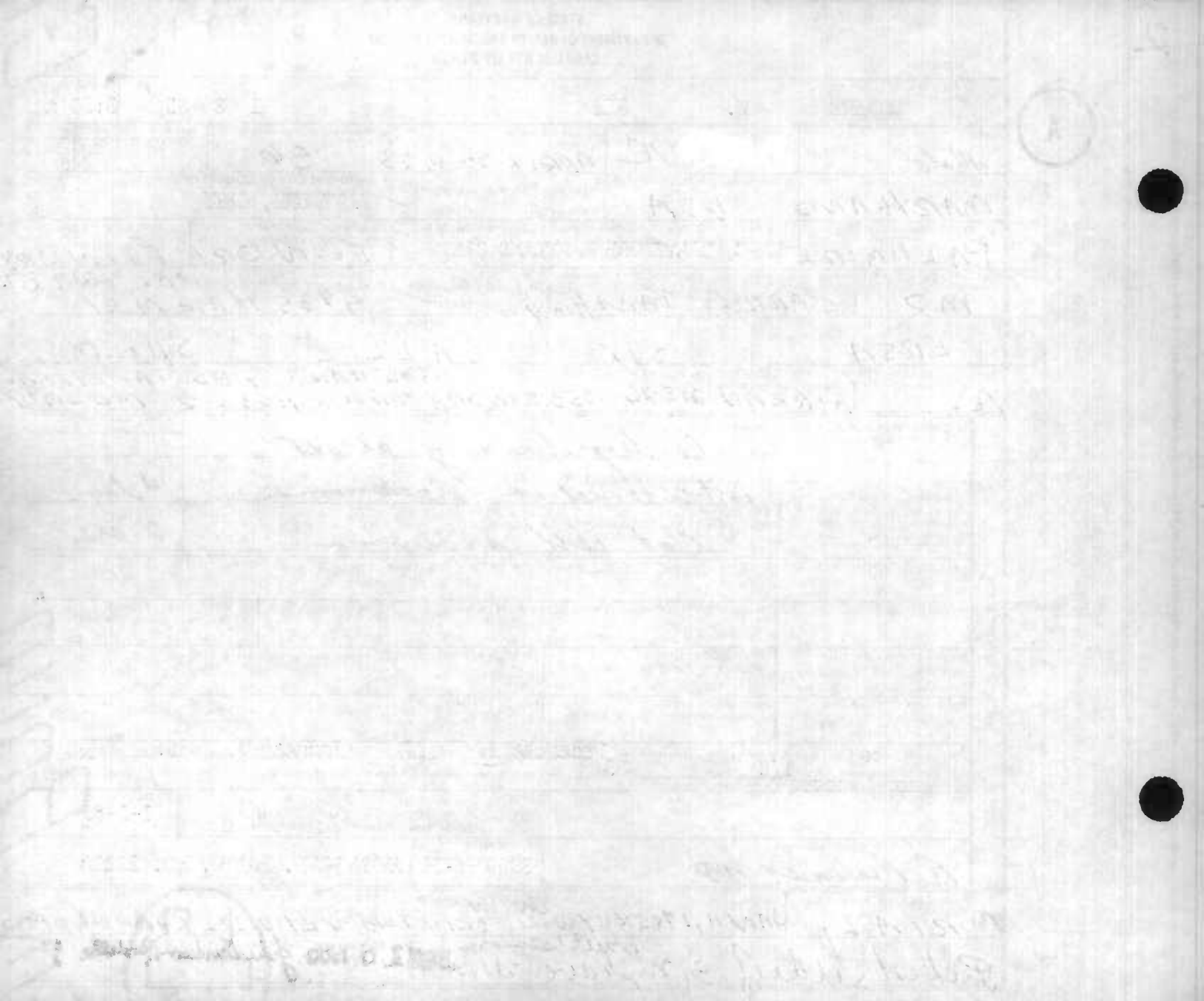
|  |  |  |  |  |  |  |  |
|--|--|--|--|--|--|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>ROBERT W. SIX</b>   |  |  |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>1 8 85</b>   |  | 2b. HOUR<br><b>3:50 am</b>   |  |
| 3. SEX<br><b>Male</b>  |  | 4. RACE<br><b>CAUC</b>   |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>APRIL 30 1928</b>   |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>56</b> YRS.  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>MARYLAND</b>   |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>BALTIMORE, CITY</b> MD.   |  |
| 10. CITY OR TOWN OF DEATH<br><b>BALTIMORE</b>  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>VAMC, BALTIMORE MARYLAND 21218</b> |  |  |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>FOUNDRY</b>   |  |
| 13a. STATE<br><b>MD</b>  |  | 13b. COUNTY<br><b>CARROLL</b>  |  | 13c. CITY OR TOWN<br><b>TANETOWN</b>   |  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                            |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>ERSA JIX</b>  |  |  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>VALLIE SHOEMAKER</b>   |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>YES</b>   |  | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br><b>KOREAN 215-26-1253</b>   |  | 17. INFORMANT<br><b>4835 HARNEY RD. SANDRA STRICKHOUSER MD 21787</b>   |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Cardiopulmonary arrest</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. <b>Pneumonia</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <b>Lat cell carcinoma</b> |  |  |  |  |  |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1. (a) <b>4 days</b><br>(b) <b>2 yrs</b>   |  |  |  |  |  |  |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>  |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)   |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM ETC.)  |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE  |  |  |  |
| 22a. I certify that (X) (this hospital) attended the deceased from <b>December 28, 19 84</b> , to <b>January 8, 19 85</b> , that (we) last saw the deceased alive on <b>1/8 1985</b> , and that in (our) opinion death occurred on the date and hour and from the causes stated above (X) (we) (did not) view the body after death.  |  |  |  |  |  |  |  |
| 22b. SIGNATURE<br><b>R. Bennier MD</b>   |  |  |  | DEGREE<br>ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>        |  | 22c. DATE SIGNED<br><b>1-8-85</b>  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)  |  |  |  | 22e. ADDRESS<br><b>3900 LOCH RAVEN BLVD. BALTO. MD. 21218</b>  |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>BURIAL</b>   |  | 23b. DATE<br><b>JAN 11, 1985</b>   |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>KETSVILLE CEMETERY</b>  |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>KETSVILLE, CARROLL, MD</b>  |  |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>Paul of Little G. 34 Mylave</b>   |  |  |  | 25. DATE RECD. BY REGISTRAR<br><b>JAN 16 1985</b>  |  |  |  |

BP. \_\_\_\_\_

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial permit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified and a medical examiner must be notified.



STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 5 0 1 5 4 0

FOR  
1 - STATE  
REGISTRAR

REG. NO.

|  |  |   |  |   |   |   |  |  |  |
|--|--|---|--|---|---|---|--|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>FIRST MIDDLE LAST<br>RUTH CORDENIA Slocum   |  |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br>1-20-85 |   | 2b. HOUR<br>9 <sup>10</sup> A M   |   |  |  |  |
| 3. SEX<br>F  |  | 4. RACE<br>B  |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>10 20 20  |   | 6. AGE (IN YEARS LAST BIRTHDAY)<br>64 YRS   |  | 7. IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS<br>HOURS MIN.                                 |  |
| 8a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Maryland  |  | 8b. CITIZEN OF WHAT COUNTRY?<br>U.S.A.  |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Baltimore City, MD.   |  |  |  |
| 10. CITY OR TOWN OF DEATH<br>Baltimore   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>Saint Agnes Hospital |  |   |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)  |  | 12b. KIND OF BUSINESS OR INDUSTRY  |  |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE Maryland 13b. COUNTY 13c. CITY OR TOWN Baltimore   |  |   |  |   |   | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>   |  |  |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>William Deaver Keene   |  |   |  |   |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Amy Ross   |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br>NO   |  | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br>213-14-7872  |  | 17. INFORMANT ADDRESS<br>George Slocum 27 N. Monastery Avenue   |   |   |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Cardiorespiratory arrest</u><br>DUE TO, OR AS A CONSEQUENCE OF (b) <u>Cocaine</u><br>DUE TO, OR AS A CONSEQUENCE OF (c) <u>Metastatic bladder cancer</u>  |  |   |  |   |   |   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><u>Immediate</u><br><u>1 month</u><br><u>4 mo.</u> |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <u>None</u>   |  |   |  |   |   |   |  |  |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |   | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |   |   |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |   |   |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>7/84</u> , 19 <u>84</u> , to <u>1/20</u> , 19 <u>85</u> , that (I) (we) last saw the deceased alive on <u>1/19</u> , 19 <u>85</u> , and that in my (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |  |   |  |   |   |   |  |  |  |
| 22b. SIGNATURE<br><u>Wm C Waterfield</u>   |  |   |  | DEGREE<br><u>MO</u>   |   | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL STAFF <input type="checkbox"/><br>PHYSICIAN <input type="checkbox"/> DIRECTOR <input type="checkbox"/> PHYSICIAN <input type="checkbox"/> |  | 22c. DATE SIGNED<br><u>1/20/85</u>   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><u>Wm C Waterfield MO</u>   |  |   |  | 22e. ADDRESS<br><u>St Agnes Hospital</u><br><u>900 Caton Ave Balt 21229.</u>  |   |   |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>BURIAL  |  | 23b. DATE<br>1/24/85  |  | 23c. NAME OF CEMETERY OR CREMATORY<br>King Memorial Park  |   | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Randallstown, Md.   |  |  |  |
| 24. FUNERAL DIRECTOR<br>NAME<br>Wm C March F/H Inc.  |  |   |  | ADDRESS<br>1101 E North Avenue  |   | 25a. DATE REC'D. BY REGISTRAR<br>JAN 22 1985  |  | 25b. REGISTRAR'S SIGNATURE<br><u>in Davidson-Randall</u>   |  |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.  
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.



STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 5 0 1 5 4 1

FOR  
1 - STATE  
REGISTRAR

REG. NO.

|  |   |  |   |  |   |
|--|---|--|---|--|---|
| 1 DECEASED NAME<br>(TYPE OR PRINT)<br>FIRST MIDDLE LAST<br>JOHN S. SLOWIKOWSKI                                   |   |  | 2a DATE OF DEATH<br>MONTH DAY YEAR<br>JANUARY 25, 1985                  |  | 2b HOUR<br>1:55 P.M.                        |
| 3 SEX<br>MALE  | 4 RACE<br>WHITE   | 5 DATE OF BIRTH<br>MONTH DAY YEAR<br>12 28 1913  |   | 6 AGE (IN YEARS LAST BIRTHDAY)<br>71 YRS   | 7 IF UNDER 1 YEAR<br>MONTHS DAYS HOURS MIN. |
| 7a BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>MARYLAND   | 7b CITIZEN OF WHAT COUNTRY?<br>U.S.A.   | 8 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9 BALTIMORE CITY OR COUNTY OF DEATH<br>BALTIMORE CITY MD.                                      |   |
| 10 CITY OR TOWN OF DEATH<br>BALTIMORE  | 11 NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>CHURCH HOSPITAL |  | 12a USUAL OCCUPATION<br>(TYPE WORK FOR MOST OF WORKING LIFE)<br>RETIRED |  | 12b KIND OF BUSINESS OR INDUSTRY            |
| 13a USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>STATE<br>MARYLAND |   | 13b COUNTY   | 13c CITY OR TOWN<br>BALTIMORE   | 13d INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |   |
| 14 FATHER'S NAME<br>FIRST MIDDLE LAST<br>JOSEPH SLOWIKOWSKI  |   | 15 MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>ROSALIE SZILAK   |   |  |   |
| 16a WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)<br>NO             |   | 16b SOCIAL SECURITY NO.<br>215-05-5125   |   | 17 INFORMANT<br>ADDRESS<br>AGNES WISNIEWSKI 428 S. ROBINSON ST.                                |   |

18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).  
PART 1: DEATH WAS CAUSED BY

IMMEDIATE CAUSE (a) CARDIOPULMONARY ARREST

DUE TO, OR AS A CONSEQUENCE OF

(b) CEREBRO-~~XXXXXX~~OVASCULAR ACCIDENT

DUE TO, OR AS A CONSEQUENCE OF

(c) A.S.C.V.D.

APPROXIMATE INTERVAL  
BETWEEN ONSET AND DEATH

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: NO

MEDICAL CERTIFICATION

|  |   |   |  |
|--|---|---|--|
| 19a DATE OF OPERATION  | 19b CONDITION FOR WHICH OPERATION WAS PERFORMED                       | 20a AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 20b IF YES, WERE FINDINGS USED<br>IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  | 21b TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19             | 21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)       |  |
| 21d INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>  | 21e PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | 21f LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                    |  |
| 22a I certify that (I) this hospital attended the deceased from <u>JANUARY 22, 19 85</u> to <u>JANUARY 25, 19 85</u> , that (I) <input checked="" type="checkbox"/> lost<br>saw the deceased alive on <u>JANUARY 25, 19 85</u> , and that in (my) <u>own</u> opinion death occurred on the date and hour and from the causes stated<br>above; (I) <input checked="" type="checkbox"/> did not view the body after death. |   |   |  |
| 22b SIGNATURE<br><u>Melito M. Torres</u>   | DEGREE<br><u>M.D.</u>   | 22c DATE SIGNED<br><u>1/25/85</u>   |  |
| 22d PHYSICIAN'S NAME (TYPE OR PRINT)<br>MELITO M. TORRES M.D.  |   | 22e ADDRESS<br>CHURCH HOSPITAL CORPORATION<br>100 NORTH BROADWAY BALTO., MD. 21231  |  |

|   |                       |   |  |
|---|-----------------------|---|--|
| 23a BURIAL, CREMATION, REMOVAL<br>(BY)<br>BURIAL      | 23b DATE<br>1/28/1985 | 23c NAME OF CEMETERY OR CREMATORY<br>ST. STANISLAUS | 23d LOCATION<br>CITY OR TOWN COUNTY STATE<br>BALTIMORE MD. |
| 24 FUNERAL DIRECTOR<br>NAME<br>RAYMOND L. KACZOROWSKI |                       | 25a DATE REC'D. BY REGISTRAR<br>JAN 28 1985         | 25b REGISTRAR'S SIGNATURE<br><u>John Davidson-Randall</u>  |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. It should may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be attached for use on the burial transit permit. Then please remove carbon copies. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked at item 18 shows any injury, or other traumatic event, the medical examiner will have to be called upon.





STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 01542

1- STATE REGISTRAR

|   |           |  |  |   |  |   |  |  |  |                          |  |          |  |       |  |          |  |
|---|-----------|--|--|---|--|---|--|--|--|--------------------------|--|----------|--|-------|--|----------|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)   |           | FIRST  |  | MIDDLE  |  | LAST  |  | 20. DATE KNOWN OF DEATH                      |  | MONTH                    |  | DAY      |  | YEAR  |  | 21. HOUR |  |
| CHARLES Edward SMALLWOOD  |           |  |  |   |  |   |  | 1-21-85                                      |  | 19                       |  |          |  |       |  | 2:25A    |  |
| 3. SEX  | 4. RACE   | 5. DATE OF BIRTH   |  | 6. AGE (IN YEARS)   |  | IF UNDER 1 YR.  |  | IF UNDER 24 HRS.                             |  | 72. DATE PRONOUNCED DEAD |  | MONTH    |  | DAY   |  | YEAR     |  |
| Male  | Caucasian | 9-12-1921  |  | 63 YRS.   |  |   |  |  |  | 1-21-85                  |  | 19       |  |       |  | 2:25A    |  |
| 70. BIRTHPLACE (STATE OR FOREIGN COUNTRY)   |           | 71. CITIZEN OF WHAT COUNTRY?   |  | 8. MARRIED  |  | NEVER MARRIED   |  | 9. BALTIMORE CITY OR COUNTY OF DEATH         |  |                          |  |          |  |       |  |          |  |
| Virginia  |           | USA  |  | WIDOWED   |  | DIVORCED  |  | Baltimore City                               |  |                          |  |          |  |       |  |          |  |
| 10. CITY OR TOWN OF DEATH   |           | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION   |  | 12a. USUAL OCCUPATION (TYPE OF WORK OR MOST OF WORKING LIFE)                  |  | 12b. KIND OF BUSINESS OR INDUSTRY                                   |  |  |  |                          |  |          |  |       |  |          |  |
| Baltimore   |           | South Baltimore General Hosp.  |  | Bindery Supervisor  |  | Publishing  |  |  |  |                          |  |          |  |       |  |          |  |
| 13a. STATE  |           | 13b. COUNTY  |  | 13c. CITY OR TOWN   |  | 13d. INSIDE CITY LIMITS?  |  | 13e. STREET ADDRESS                          |  |                          |  |          |  |       |  |          |  |
| Maryland  |           | N/A  |  | Baltimore   |  | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 625 Anson Ave.                               |  |                          |  |          |  |       |  | 21225    |  |
| 14. FATHER'S NAME   |           | 15. MOTHER'S MAIDEN NAME   |  | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?                                  |  | 16b. SOCIAL SECURITY NO.  |  | 17. INFORMANT                                |  | ADDRESS                  |  |          |  |       |  |          |  |
| John Thomas Smallwood   |           | Lucy Drury   |  | Yes   |  | 220-07-8194   |  | Donothy M. Smallwood                         |  | Same as #13              |  |          |  |       |  |          |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)   |           | PART I DEATH WAS CAUSED BY:  |  | IMMEDIATE CAUSE (a)   |  | Arteriosclerotic cardiovascular disease                             |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |  |                          |  |          |  |       |  |          |  |
|   |           |  |  | (b)   |  | DUE TO, OR AS A CONSEQUENCE OF                                      |  |  |  |                          |  |          |  |       |  |          |  |
|   |           |  |  | (c)   |  | DUE TO, OR AS A CONSEQUENCE OF                                      |  |  |  |                          |  |          |  |       |  |          |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1.   |           |  |  |   |  |   |  |  |  |                          |  |          |  |       |  |          |  |
| 19a. DATE OF OPERATION  |           | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?  |  | 20. AUTOPSY?  |  | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |  |  |                          |  |          |  |       |  |          |  |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH   |           | 21b. TIME OF INJURY  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) |  |   |  |  |  |                          |  |          |  |       |  |          |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK   |           | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)  |  | 21f. LOCATION   |  | CITY OR TOWN  |  | COUNTY                                       |  | STATE                    |  |          |  |       |  |          |  |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: |           | Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> |  | TITLE (SPECIFY)   |  | M.D. Assistant  |  | MEDICAL EXAMINER                             |  | DATE SIGNED              |  | 1-21-85  |  |       |  |          |  |
| ACTUAL SIGNATURE  |           | Margarita A. Korell, M.D.  |  | 111 Penn Street   |  |   |  |  |  |                          |  |          |  |       |  |          |  |
| EXAMINER'S NAME (TYPE OR PRINT)   |           | 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)  |  | 23b. DATE   |  | 23c. NAME OF CEMETERY OR CREMATORY                                  |  | 23d. LOCATION                                |  | CITY OR TOWN             |  | COUNTY   |  | STATE |  |          |  |
|   |           | Entombment   |  | 1-24-85   |  | Cedar Hill Mausoleum  |  | Baltimore                                    |  | N/A                      |  | Maryland |  |       |  |          |  |
| 24. FUNERAL DIRECTOR  |           | 25a. DATE REC'D. BY REGISTRAR  |  | 25b. REGISTRAR'S SIGNATURE  |  |   |  |  |  |                          |  |          |  |       |  |          |  |
| McCully Funeral Home of Brooklyn Baltimore, Md  |           | JAN 23 1985  |  | John Davidson-Randall   |  |   |  |  |  |                          |  |          |  |       |  |          |  |

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 24 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

07/84  
25M

BP  
DHMH - 17  
(VR A15 ME (5))

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201



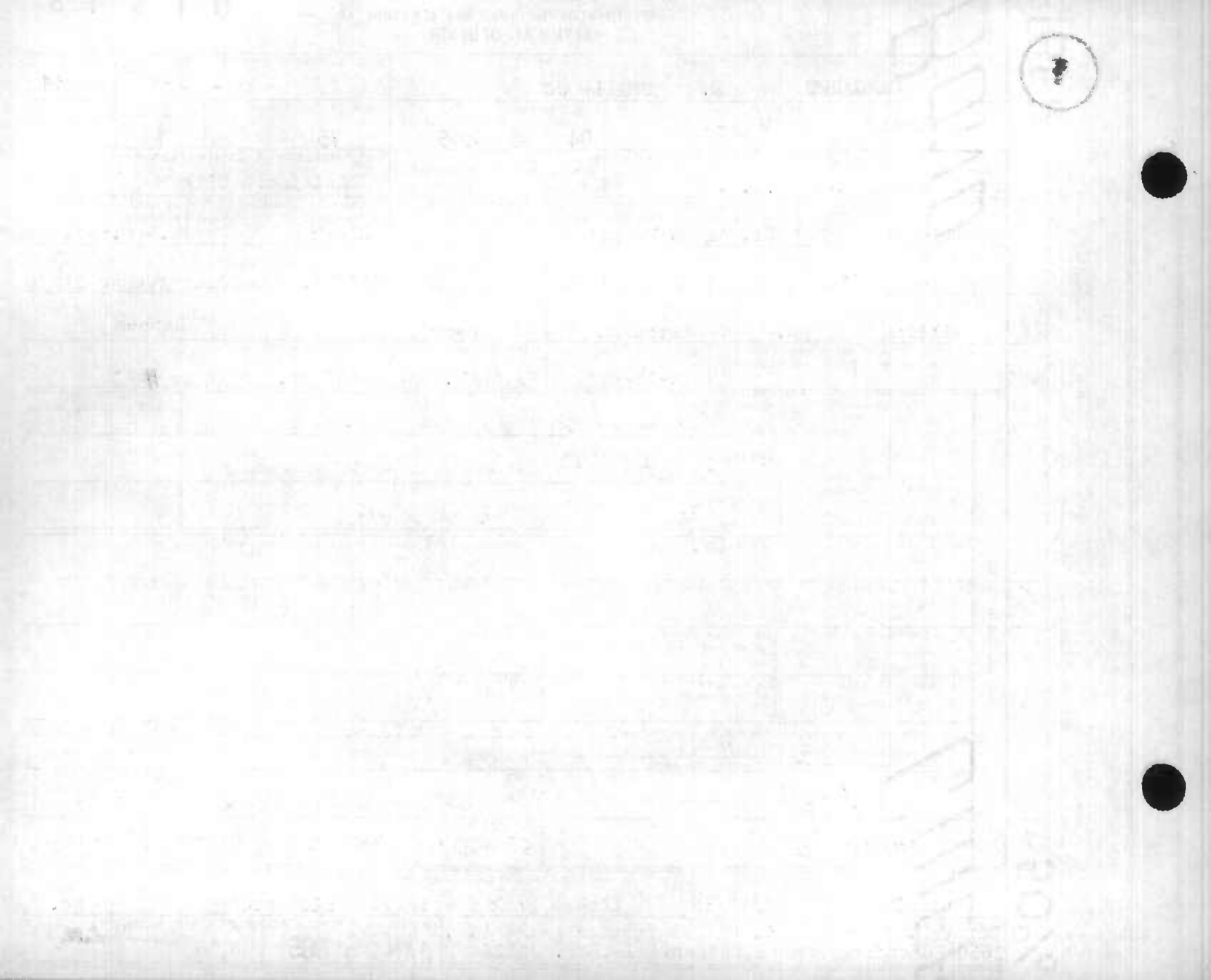
RECEIVED  
MAY 11 1964  
U.S. AIR FORCE  
HONOLULU, HAWAII

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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IMPORTANT: If item 21 is marked by item 18 above any injury, or other traumatic event, the medical examiner shall be notified of cause.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH  |   |   |  | REG. NO.   |  |
|---|---|---|--|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>MARGARET D. SMALLWOOD</b>  |   |   |  | 2a. DATE OF DEATH<br>MONTH <b>1</b> DAY <b>20</b> YEAR <b>85</b><br><b>01-20-85</b> 2b. HOUR <b>8:00A.M.</b> |  |
| 3. SEX<br><b>FEMALE</b>   | 4. RACE<br><b>White</b>                       | 5. DATE OF BIRTH<br>MONTH <b>04</b> DAY <b>05</b> YEAR <b>1909</b>  |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>75</b> YRS.<br>IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN. |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Washington, D.C.</b>  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b> | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore City MD.</b>  |  |
| 10. CITY OR TOWN OF DEATH<br><b>Baltimore</b>   |   | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>St. Agnes Hospital</b>                      |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Clerk</b>                             |  |
| 12b. KIND OF BUSINESS OR INDUSTRY<br><b>B. &amp; O. Railroad</b>  |   |   |  |  |  |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE <b>Maryland</b> 13b. COUNTY <b>Baltimore</b> 13c. CITY OR TOWN <b>Catonsville</b>  |   | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  | 13e. STREET ADDRESS / ZIP CODE<br><b>6112 B. Edmondson Avenue 21228</b>                                      |  |
| 14. FATHER'S NAME<br>FIRST <b>William</b> MIDDLE <b>M.</b> LAST <b>Ferguson</b>   |   | 15. MOTHER'S MAIDEN NAME<br>FIRST <b>Henrietta</b> MIDDLE <b>Laupus</b> LAST <b>Laupus</b>  |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) <b>No</b>  |   | 16b. SOCIAL SECURITY NO.<br><b>219-32-4257</b>  |  | 17. INFORMANT<br><b>Ralph W. Smallwood Jr. Same as # 13</b>  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Carcinoma of ovary with Cachexia</b><br>DUE TO, OR AS A CONSEQUENCE OF (b) <b>Metastasis to the pelvis + pelvic organ</b><br>DUE TO, OR AS A CONSEQUENCE OF (c) <b>Diffuse metastasis to the liver</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. |   |   |  |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a  |   |   |  |  |  |
| 19a. DATE OF OPERATION  |   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                         |  |
| 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>  |   |   |  |  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |   | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. <b>19</b>   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18. PART 1 OR PART 2)                               |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK  |   | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>1-10</b> , 19 <b>85</b> , to <b>1-20</b> , 19 <b>85</b> , that (I) (we) last saw the deceased alive on <b>1-20</b> , 19 <b>85</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.  |   |   |  |  |  |
| 22b. SIGNATURE<br><b>Philip M. ...</b>  |   | DEGREE<br><b>MD</b>   |  | 22c. DATE SIGNED<br><b>1-20-85</b>   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>PHILIP M. ...</b>   |   | 22e. ADDRESS<br><b>ST. AGNES HOSPITAL, BALTIMORE MD 21229</b>   |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY) <b>Burial</b>  |   | 23b. DATE<br><b>1/22/85</b>   |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Loudon Park Cemetery</b>  |  |
| 23d. LOCATION<br>CITY OR TOWN <b>Baltimore</b> COUNTY <b>MD.</b> STATE <b>MD.</b>   |   |   |  |  |  |
| 24. FUNERAL DIRECTOR<br>NAME <b>Leroy M. &amp; Russell C. Witzke Funeral Homes P.A.</b> ADDRESS <b>1630 Edmondson Avenue, Catonsville, Md. 21228</b>  |   |   |  | 25a. DATE REC'D. BY REGISTRAR <b>JAN 22 1985</b> 25b. REGISTRAR'S SIGNATURE <b>John Davidson-Randall</b>     |  |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH   |  |   |  | REG. NO.   |  |
|--|--|---|--|--|--|
| 1. FOR STATE REGISTRAR   |  |   |  | 7. DATE OF DEATH   |  |
| 1. DECEASED NAME (TYPE OR PRINT)   |  |   |  | 2a. DATE OF DEATH  |  |
| FIRST MIDDLE LAST  |  |   |  | MONTH DAY YEAR   |  |
| MARGARET E SMEDLEY   |  |   |  | 1/29/85  |  |
| 3. SEX   |  |   |  | 4. RACE  |  |
| Female   |  |   |  | CAUCASIAN  |  |
| 5. DATE OF BIRTH   |  |   |  | 6. AGE (IN YEARS LAST BIRTHDAY)  |  |
| MONTH DAY YEAR   |  |   |  | YRS. MONTHS DAYS HOURS MIN.  |  |
| 9/20/12  |  |   |  | 72   |  |
| 7b. BIRTHPLACE (STATE OR FOREIGN COUNTRY)  |  |   |  | 7c. CITIZEN OF WHAT COUNTRY?   |  |
| Maryland   |  |   |  | U.S.A.   |  |
| 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>   |  |   |  | 9. BALTIMORE CITY OR COUNTY OF DEATH   |  |
| 10. CITY OR TOWN OF DEATH  |  |   |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)                  |  |
| Baltimore  |  |   |  | Housewife  |  |
| 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)   |  |   |  | 12b. KIND OF BUSINESS OR INDUSTRY  |  |
| South Baltimore General Hosp.  |  |   |  | own home   |  |
| 13a. STATE   |  |   |  | 13b. COUNTY  |  |
| MD   |  |   |  | BALT.  |  |
| 13c. CITY OR TOWN  |  |   |  | 13d. INSIDE CITY LIMITS?   |  |
| BALT.  |  |   |  | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>            |  |
| 14. FATHER'S NAME  |  |   |  | 15. MOTHER'S MAIDEN NAME   |  |
| FIRST MIDDLE LAST  |  |   |  | FIRST MIDDLE LAST  |  |
| FRANK — HELLINGS   |  |   |  | MARY — SCHWINGER   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)  |  |   |  | 16b. SOCIAL SECURITY NO.   |  |
| no   |  |   |  | 217-505-100  |  |
| 17. INFORMANT  |  |   |  | ADDRESS  |  |
| Hospital Records   |  |   |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)  |  |   |  |  |  |
| PART I. DEATH WAS CAUSED BY:   |  |   |  |  |  |
| IMMEDIATE CAUSE (a) <u>CARDIAC ARREST.</u>   |  |   |  |  |  |
| DUE TO, OR AS A CONSEQUENCE OF   |  |   |  |  |  |
| (b) <u>ADENOCARCINOMA OF COLON WITH METASTATIC DISEASE.</u>  |  |   |  |  |  |
| DUE TO, OR AS A CONSEQUENCE OF   |  |   |  |  |  |
| (c) _____  |  |   |  |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 11a:   |  |   |  |  |  |
| <u>HEPATORENAL FAILURE.</u>  |  |   |  |  |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                    |  | 20a. AUTOPSY?  |  |
| 1/85   |  | EXPLORATORY LAPAROTOMY  |  | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>            |  |
| 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?   |  |   |  |  |  |
| YES <input type="checkbox"/> NO <input type="checkbox"/>   |  |   |  |  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) |  |
|  |  | HOUR A.M. MONTH DAY YEAR  |  |  |  |
|  |  | P.M. 19   |  |  |  |
| 21d. INJURY OCCURRED   |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) |  | 21f. LOCATION  |  |
| AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  |  |   |  | CITY OR TOWN COUNTY STATE  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>1-29/85</u> , 19____, to <u>1/29/85</u> , 19____, that (I) (we) last saw the deceased alive on <u>1/29/85</u> , 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |  |   |  |  |  |
| 22b. SIGNATURE   |  | DEGREE  |  | 22c. DATE SIGNED   |  |
| <u>Daniel T. Redford</u>   |  |   |  | 1/29/85  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)  |  | 22e. ADDRESS  |  |  |  |
| DANIEL T. REDFORD  |  | 3001 S. HANOVER ST. BALTO. MD.                                      |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)  |  | 23b. DATE   |  | 23c. NAME OF CEMETERY OR CREMATORY   |  |
| BURIAL   |  | 2/1/85  |  | Woodlawn Cemetery  |  |
| 24. FUNERAL DIRECTOR   |  | 25a. DATE REC'D. BY REGISTRAR                                       |  | 25b. REGISTRAR'S SIGNATURE   |  |
| NAME ADDRESS   |  | JAN 30 1985   |  | <u>John T. Anderson</u>  |  |
| AMBROSE, INC 1328 SULPHUR SPRING ROAD  |  |   |  |  |  |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been completed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH  |  |  |  | REG. NO.   |   |
|---|--|--|--|--|---|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>FIRST MIDDLE LAST<br><b>ALICE E SMITH</b>  |  |  |  | 2a. DATE OF DEATH MONTH DAY YEAR<br><b>JANUARY 5, 1985</b>                                   |   |
| 3. SEX<br><b>Female</b>   |  | 4. RACE<br><b>Caucasian</b>  |  | 5. DATE OF BIRTH MONTH DAY YEAR<br><b>9-14-1898</b>  |   |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Md.</b>   |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>   |  | 6. AGE (IN YEARS LAST BIRTHDAY) YRS MONTHS DAYS<br><b>86 yrs.</b>                            |   |
| 10. CITY OR TOWN OF DEATH<br><b>BALTIMORE</b>   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>JOHNS HOPKINS HOSPITAL</b> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>BALTIMORE CITY</b> MD.                            |   |
| 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Homemaker</b>   |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>Home</b>   |  |  |   |
| 13a. STATE<br><b>Md.</b>  |  | 13b. COUNTY<br><b>Baltimore</b>  |  | 13c. CITY OR TOWN<br><b>Baltimore</b>  |   |
| 14. FATHER'S NAME FIRST MIDDLE LAST<br><b>Oliver K. Drury</b>   |  | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST<br><b>Alice E. Wicks</b>  |  | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |   |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)<br><b>no</b>  |  | 16b. SOCIAL SECURITY NO.<br><b>220-30-1949</b>   |  | 17. INFORMANT ADDRESS<br><b>Alice Kelly 3839 Bonview Ave. 21213</b>                          |   |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Cardiopulmonary Arrest</b><br>DUE TO, OR AS A CONSEQUENCE OF (b) <b>Meningitis and Sepsis</b><br>DUE TO, OR AS A CONSEQUENCE OF (c) _____<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last  |  |  |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>1 min</b><br><b>3 days</b> |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: _____  |  |  |  |  |   |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>            |   |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. <b>19</b>  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)               |   |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>  |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION CITY OR TOWN COUNTY STATE  |   |
| 22a. I certify that (I) (his, her, or their) attended the deceased from <b>1/2</b> 19 <b>85</b> to <b>1/5</b> 19 <b>85</b> , that (I) <input checked="" type="checkbox"/> saw the deceased alive on <b>1/5</b> 19 <b>85</b> , and that in (my) <input checked="" type="checkbox"/> opinion death occurred on the date and hour and from the causes stated above, (I) <input checked="" type="checkbox"/> did not view the body after death. |  |  |  |  |   |
| 22b. SIGNATURE<br><b>Henny Paul Parkman MD</b>  |  | DEGREE<br><b>MD</b>  |  | 22c. DATE SIGNED<br><b>1/5/85</b>  |   |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>Henny Parkman</b>   |  | 22e. ADDRESS<br><b>600 N WOLFE ST BALTO, MD 21205</b>  |  |  |   |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>Burial</b>  |  | 23b. DATE<br><b>1-8-85</b>   |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Holy Redeemer Cemetery</b>                          |   |
| 24. FUNERAL HOME<br><b>Schmunk Funeral Home, Inc.</b>   |  | 25a. DATE REC'D. BY REGISTRAR<br><b>JAN 8 1985</b>   |  | 25b. REGISTRAR'S SIGNATURE<br><b>Julia Davidson-Randall</b>                                  |   |
| 23d. LOCATION CITY OR TOWN COUNTY STATE<br><b>Balto., Md.</b>   |  | 23e. ADDRESS<br><b>3331 Brehms Lane, Balto., Md. 21213</b>   |  |  |   |

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1880:



*Handwritten text, possibly a signature or date, in the center of the page.*

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

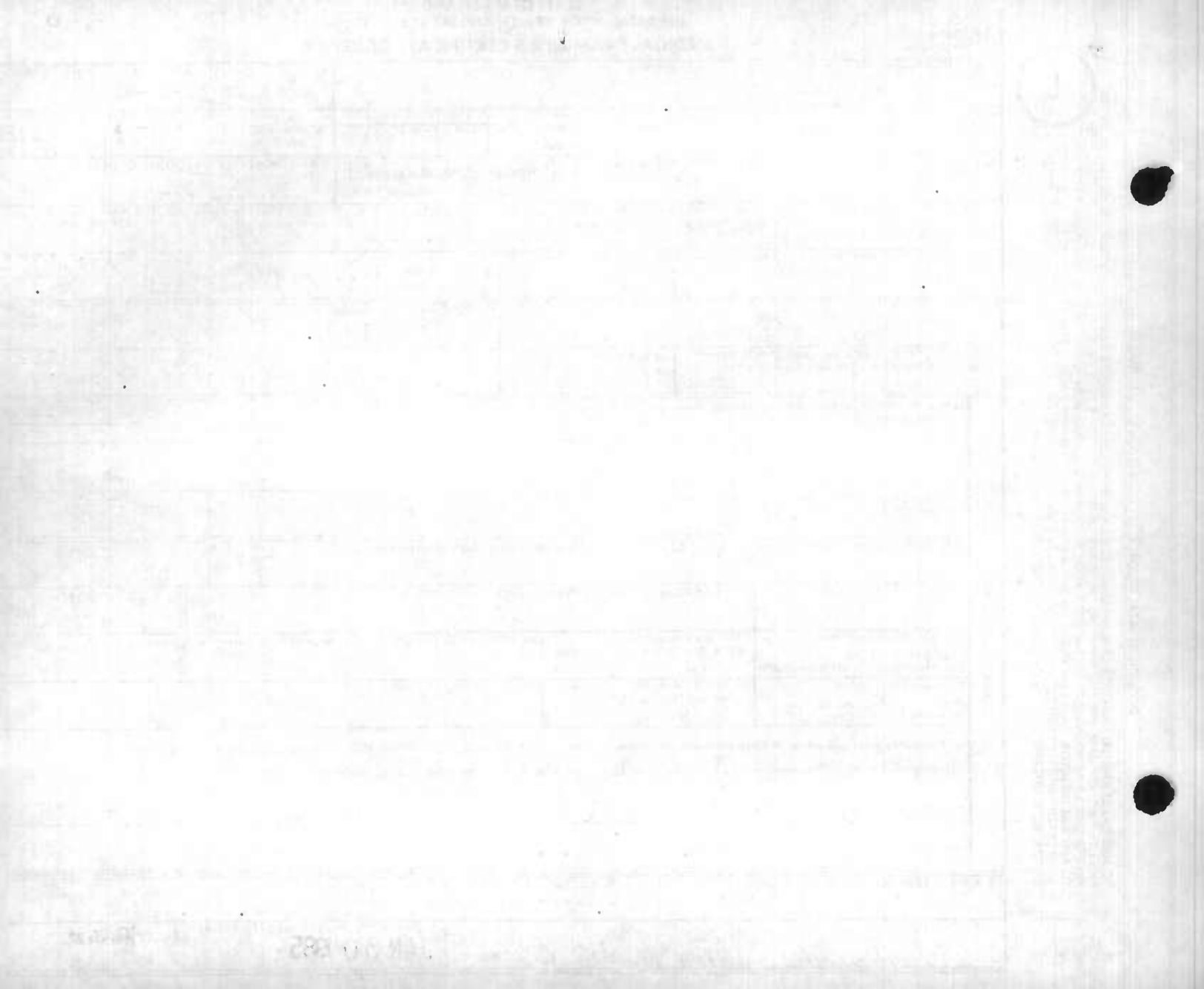
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 STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

 FOR  
1- STATE  
REGISTRAR

|  |                  |  |   |   |  |   |                   |  |
|--|------------------|--|---|---|--|---|-------------------|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>Ann (BESSIE) SMITH  |                  |  | 2a. DATE KNOWN OF DEATH<br>ESTIMATED<br>1-26-85 |   |  | 2b. HOUR<br>11:25   |                   |  |
| 3. SEX<br>Female   | 4. RACE<br>Black | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>4 12 09  | 6. AGE (IN YEARS)<br>(LAST BIRTHDAY)<br>75 YRS. | IF UNDER 1 YR.<br>MONTHS DAYS HOURS MIN   | IF UNDER 24 HRS.   | 7c. DATE PRONOUNCED DEAD<br>1-26-85   | 7d. HOUR<br>11:25 |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Md.   |                  | 7b. CITIZEN OF WHAT COUNTRY?<br>USA  |   | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Baltimore City MD                           |                   |  |
| 10. CITY OR TOWN OF DEATH<br>Baltimore   |                  | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>1100 Pennsylvania Avenue Apt. 1303 |   |   |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)                       |                   | 12b. KIND OF BUSINESS OR INDUSTRY            |
| 13a. STATE<br>Md.  |                  | 13b. COUNTY  | 13c. CITY OR TOWN<br>Balto.                     | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>   | 13e. STREET ADDRESS<br>21201 Apt. 1303<br>1100 Pennsylvania Ave. |   |                   |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>Alexander Smith  |                  |  |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Flossie R. Minor   |  |   |                   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO, OR UNKNOWN)<br>No  |                  | 16b. SOCIAL SECURITY NO.   |   | 17. INFORMANT ADDRESS<br>St.<br>Rev. Angus A. Smith 1839 N. Register  |  |   |                   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c):)<br>PART I DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) Hypertensive arteriosclerotic cardiovascular disease<br>(b) disease<br>(c) DUE TO, OR AS A CONSEQUENCE OF  |                  |  |   |   |  |   |                   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)   |                  |  |   |   |  |   |                   |  |
| 19a. DATE OF OPERATION   |                  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?  |   |   |  | 20. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |                   |  |
| 21a. EXTERNAL CAUSE WAS<br>UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH   |                  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19   |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)   |  |   |                   |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  |                  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)  |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |   |                   |  |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> . |                  |  |   |   |  |   |                   |  |
| ACTUAL SIGNATURE<br>Margarita A. Korell, M.D.  |                  | TITLE (SPECIFY)<br>Assistant   |   |   |  | DATE SIGNED<br>1-28-85  |                   |  |
| EXAMINER'S NAME<br>(TYPE OR PRINT)   |                  | ADDRESS<br>111 Penn Street   |   |   |  |   |                   |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br>Burial   |                  | 23b. DATE<br>2/1/85  |   | 23c. NAME OF CEMETERY OR CREMATORY<br>Mt. Calvary Cem.  |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Balto. Md.                            |                   |  |
| 24. FUNERAL DIRECTOR<br>NAME<br>W.C. March   |                  |  |   | ADDRESS<br>1101 North Ave   |  | 25a. DATE REC'D. BY REGISTRAR<br>JAN 30 1985  |                   | 25b. REGISTRAR'S SIGNATURE<br>[Signature]    |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1- FOR  
STATE  
REGISTRAR

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|   |  |  |  |  |  |  |  |   |  |
|---|--|--|--|--|--|--|--|---|--|
| 1 DECEASED NAME<br>(TYPE OR PRINT) <b>BLANCHE V. SMITH.</b>   |  |  | 2a. DATE OF DEATH MONTH DAY YEAR<br><b>1-13-85</b> |  |  | 2b. HOUR<br><b>10:15am</b>   |  |   |  |
| 3 SEX<br><b>FEMALE</b>  |  | 4 RACE<br><b>WHITE</b>   |  | 5 DATE OF BIRTH MONTH DAY YEAR<br><b>8-28-86</b>   |  | 6 AGE (IN YEARS LAST BIRTHDAY)<br><b>98</b>  |  | IF UNDER 1 YEAR<br>MONTHS DAYS HOURS MIN.<br>IF UNDER 24 HRS.   |  |
| 7a BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Maryland</b>   |  | 7b CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>   |  | 8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9 BALTIMORE CITY OR COUNTY OF DEATH<br><b>BALTIMORE CITY</b> MD.                               |  |   |  |
| 10 CITY OR TOWN OF DEATH<br><b>BALTIMORE</b>  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Lafayette Nursing Center Balto. Md.</b> |  |  |  | 12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>None</b>                    |  | 12b KIND OF BUSINESS OR INDUSTRY  |  |
| 13a STATE<br><b>MARYLAND</b>  |  | 13b COUNTY<br><b>-</b>   |  | 13c CITY OR TOWN<br><b>BALTIMORE</b>   |  | 13d INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 13e STREET ADDRESS<br><b>140 W. Lafayette Ave. Balto. Md.</b>   |  |
| 14 FATHER'S NAME FIRST MIDDLE LAST<br><b>Fred - Kleinherren</b>   |  |  |  | 15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST<br><b>Virginia - Clark</b>   |  |  |  |   |  |
| 16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)<br><b>No</b>   |  | 16b SOCIAL SECURITY NO.<br><b>213-54-1836</b>  |  | 17 INFORMANT ADDRESS<br><b>Ethel Forrester, 130 E. Font Ave. Balto. Md.</b>  |  |  |  |   |  |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>CARDIO-PULMONARY ARREST</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost<br>(b) <b>ATRIAL FIBRILLATION</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <b>ASCVD</b> |  |  |  |  |  |  |  |   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I:  |  |  |  |  |  |  |  |   |  |
| 19a DATE OF OPERATION   |  | 19b CONDITION FOR WHICH OPERATION WAS PERFORMED  |  |  |  | 20a AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>                       |  | 20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>  |  | 21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18: PART I OR PART 2)  |  |  |  |   |  |
| 21d INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK   |  | 21e PLACE OF INJURY [AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.]   |  | 21f LOCATION STREET CITY OR TOWN COUNTY STATE  |  |  |  |   |  |
| 22a I certify that (I) (this hospital) attended the deceased from <b>5-8, 1985</b> , to <b>1-13, 1985</b> , that (I) (we) lost<br>saw the deceased alive on <b>1-3, 1985</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated<br>above. (If we did not view the body after death.)   |  |  |  |  |  |  |  |   |  |
| 22b SIGNATURE<br><b>Franklin M.D.</b>   |  |  |  | DEGREE<br><b>M.D.</b>  |  |  |  | 22c DATE SIGNED   |  |
| 22d PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>FRANKLIN A.</b>  |  |  |  | 22e ADDRESS<br><b>2600 GARRISON RD BALD 21216</b>  |  |  |  |   |  |
| 23a BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>Burial</b>   |  | 23b DATE<br><b>Jan. 14, 1985</b>   |  | 23c NAME OF CEMETERY OR CREMATORY<br><b>Cedar Hill Cemetery</b>  |  | 23d LOCATION CITY OR TOWN COUNTY STATE<br><b>Baltimore, Maryland</b>                           |  |   |  |
| 24 FUNERAL DIRECTOR<br><b>McCutty Funeral Home, 130 E. Font Ave. Balto. Md.</b>   |  |  |  | 25a DATE REC'D. BY REGISTRAR<br><b>JAN 14 1985</b>   |  | 25b REGISTRAR'S SIGNATURE<br><b>Juha Davidson-Rendall</b>                                      |  |   |  |

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STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 5 0 1 5 4 8

FOR  
STATE  
REGISTRAR

REG. NO.

|  |  |  |   |  |  |  |   |   |  |                                  |  |
|--|--|--|---|--|--|--|---|---|--|----------------------------------|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br><b>CAROLE J. SMITH</b>  |  |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>1 31 85</b>                         |  |  | 2b. HOUR<br><b>3:24 PM</b>   |   |   |  |                                  |  |
| 3. SEX<br><b>Female</b>  |  | 4. RACE<br><b>Black</b>  |   | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>5 15 42</b>   |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>42</b> YRS.  |   | 7. IF UNDER 1 YEAR<br>MONTHS DAYS   |  | 8. IF UNDER 24 HRS<br>HOURS MIN. |  |
| 9. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Maryland</b>  |  | 10. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>  |   | 11. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> |  | 12. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore City</b> MD.   |   |   |  |                                  |  |
| 13. CITY OR TOWN OF DEATH<br><b>Baltimore</b>  |  | 14. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>SINAI HOSP</b> |   |  |  | 15. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Supervisor- Md. State Education</b>                                      |   |   |  | 16. KIND OF BUSINESS OR INDUSTRY |  |
| 17. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>17a. STATE<br><b>MD</b>   |  | 17b. COUNTY<br><b>13b. COUNTY</b>  |   | 17c. CITY OR TOWN<br><b>BALTO</b>  |  | 17d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |   | 17e. STREET ADDRESS<br><b>4306 Danlou Drive<br/>Baltimore, Maryland 21207</b> |  |                                  |  |
| 18. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Daniel Johnson</b>  |  |  |   | 19. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Emma Hall</b>  |  |  |   | 20. ADDRESS<br><b>1002 W. 43rd. Street<br/>Baltimore, Md. 21211</b>           |  |                                  |  |
| 21a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)<br><b>No.</b>   |  | 21b. SOCIAL SECURITY NO.<br><b>216-38-3534</b>   |   | 21c. INFORMANT<br><b>Christine Franklin</b>  |  | 21d. ADDRESS<br><b>Baltimore, Md. 21211</b>  |   |   |  |                                  |  |
| 22. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>SEPTIC SHOCK</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) <b>SEPSIS</b><br>DUE TO, OR AS A CONSEQUENCE OF (c) <b>LYMPHOMA, METS.</b> |  |  |   |  |  |  |   |   |  |                                  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a   |  |  |   |  |  |  |   |   |  |                                  |  |
| 23a. DATE OF OPERATION   |  |  | 23b. CONDITION FOR WHICH OPERATION WAS PERFORMED                              |  |  |  | 23c. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |   | 23d. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |                                  |  |
| 24a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  |  | 24b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>19 85</b>               |  |  | 24c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18: PART 1 OR PART 2)   |   |   |  |                                  |  |
| 24d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK   |  |  | 24e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)        |  |  | 24f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE  |   |   | 24g. DATE SIGNED<br><b>1/31/85</b>   |                                  |  |
| 25. I certify that (I) (this hospital) attended the deceased from <b>1/31</b> 19 <b>85</b> to <b>1/31</b> 19 <b>85</b> , that (I) (we) last saw the deceased alive on <b>1/31</b> 19 <b>85</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.              |  |  |   |  |  |  |   |   |  |                                  |  |
| 26. SIGNATURE<br><b>J. Young</b>   |  |  | 26. DEGREE<br><b>MD</b>   |  |  | 26. ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> |   |   | 26. DATE SIGNED<br><b>1/31/85</b>  |                                  |  |
| 27. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>J. Young</b>  |  |  | 27. ADDRESS<br><b>SINAI HOSP</b>  |  |  | 27. LOCATION<br>CITY OR TOWN COUNTY STATE  |   |   | 27. NAME OF CEMETERY OR CREMATORY<br><b>Asbury United Methodist Cemetery</b>   |                                  |  |
| 28. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>Burial</b>   |  |  | 28. DATE<br><b>2/4/1985</b>   |  |  | 28. LOCATION<br>CITY OR TOWN COUNTY STATE  |   |   | 28. NAME OF CEMETERY OR CREMATORY<br><b>Harford Co., Maryland</b>  |                                  |  |
| 29. FUNERAL DIRECTOR'S NAME<br><b>Mutter &amp; Sons</b>  |  |  | 29. ADDRESS<br><b>2501 Gwynns Falls Parkway<br/>Baltimore, Maryland 21216</b> |  |  | 29. DATE REC'D. BY REGISTRAR<br><b>FEB 7 1985</b>  |   |   | 29. REGISTRAR'S SIGNATURE<br><b>J. A. Henderson-Randall</b>  |                                  |  |

OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be  
by the hospital or attending physician.

FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 3 and 4 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the Medical Examiner must be notified at once.

Baltimore  
Maryland

Jack

Baltimore City

Supervisor - No. 25 to Education  
308 Daniel Drive  
Baltimore, Maryland 21207

Daniel

Johnson

Frank

Christine Franklin  
1002 W. 43rd Street  
Baltimore, Md. 21211

No.

516-38-3534

Asbury United Methodist

Cemetery

11/1982

Serial

Notary & Sons 2501 Gwynns Falls Parkway

Phoenix Home Inc. Baltimore, Maryland 21216

Harford Co., Maryland



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked on item 1B about any injury, or other traumatic event, the medical examiner must be notified and page 4 must be completed.

FOR  
1. STATE  
REGISTRAR

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|  |   |   |   |  |   |  |
|--|---|---|---|--|---|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>EDMOND J. Smith</b>   |   |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>1.24.85</b>   |  | 2b. HOUR<br>MIN.<br><b>12:30 AM</b>   |  |
| 3. SEX<br><b>M</b>   | 4. RACE<br><b>B</b>   | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>1 9 13</b>   |   | 6. AGE (IN YEARS LAST BIRTHDAY)<br>YRS MONTHS DAYS<br><b>72</b>                            |   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>N.C.</b>   | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>BALTO CITY</b> MD.                              |   |  |
| 10. CITY OR TOWN OF DEATH<br><b>Baltimore</b>  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>3701 W. Garrison Ave.</b> |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)                                |  | 12b. KIND OF BUSINESS OR INDUSTRY   |  |
| 13a. STATE<br><b>MD</b>  | 13b. COUNTY   | 13c. CITY OR TOWN<br><b>Baltimore</b>   | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | 13e. STREET ADDRESS / ZIP CODE<br><b>3701 W. GARRISON AVE 21215</b>                        |   |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Edmond Smith</b>  |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Lorena Williams</b>   |   |  |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) <b>yes</b>  |   | 16b. SOCIAL SECURITY NO.<br><b>238 187393</b>   |   | 17. INFORMANT<br>ADDRESS<br><b>Mildred Smith 3701 W. Garrison Ave.</b>                     |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Cardiovascular ALBERT.</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <b>GASTRIC CARCINOMA</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <b>5 yrs.</b>  |   |   |   |  | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH   |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <b>no</b>   |   |   |   |  |   |  |
| 19a. DATE OF OPERATION   |   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>                  | 20b. IF YES, WERE FINDINGS USED<br>IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |   | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18. PART 1 OR PART 2)             |   |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK   |   | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE  |   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>11/15</b> , 19 <b>85</b> , to <b>1/24/85</b> , that (I) (we) last saw the deceased alive on <b>1/24/85</b> , 19 <b>85</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |   |   |   |  |   |  |
| 22b. SIGNATURE<br><b>[Signature]</b>   |   | DEGREE<br>ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>        |   | 22c. DATE SIGNED<br><b>1/24/85</b>   |   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)  |   | 22e. ADDRESS  |   |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY) <b>Burial</b>   |   | 23b. DATE<br><b>1/28/85</b>   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Md. Veteran Cem.</b>                                   |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Crownsville MD</b>   |  |
| 24. FUNERAL DIRECTOR<br>NAME <b>Wm. C. March F/H</b>   |   | ADDRESS <b>1101 E. North Ave.</b>   |   | 25a. DATE REC'D. BY REGISTRAR 25b. REGISTRAR'S SIGNATURE<br><b>JAN 25 1985 [Signature]</b> |   |  |



DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

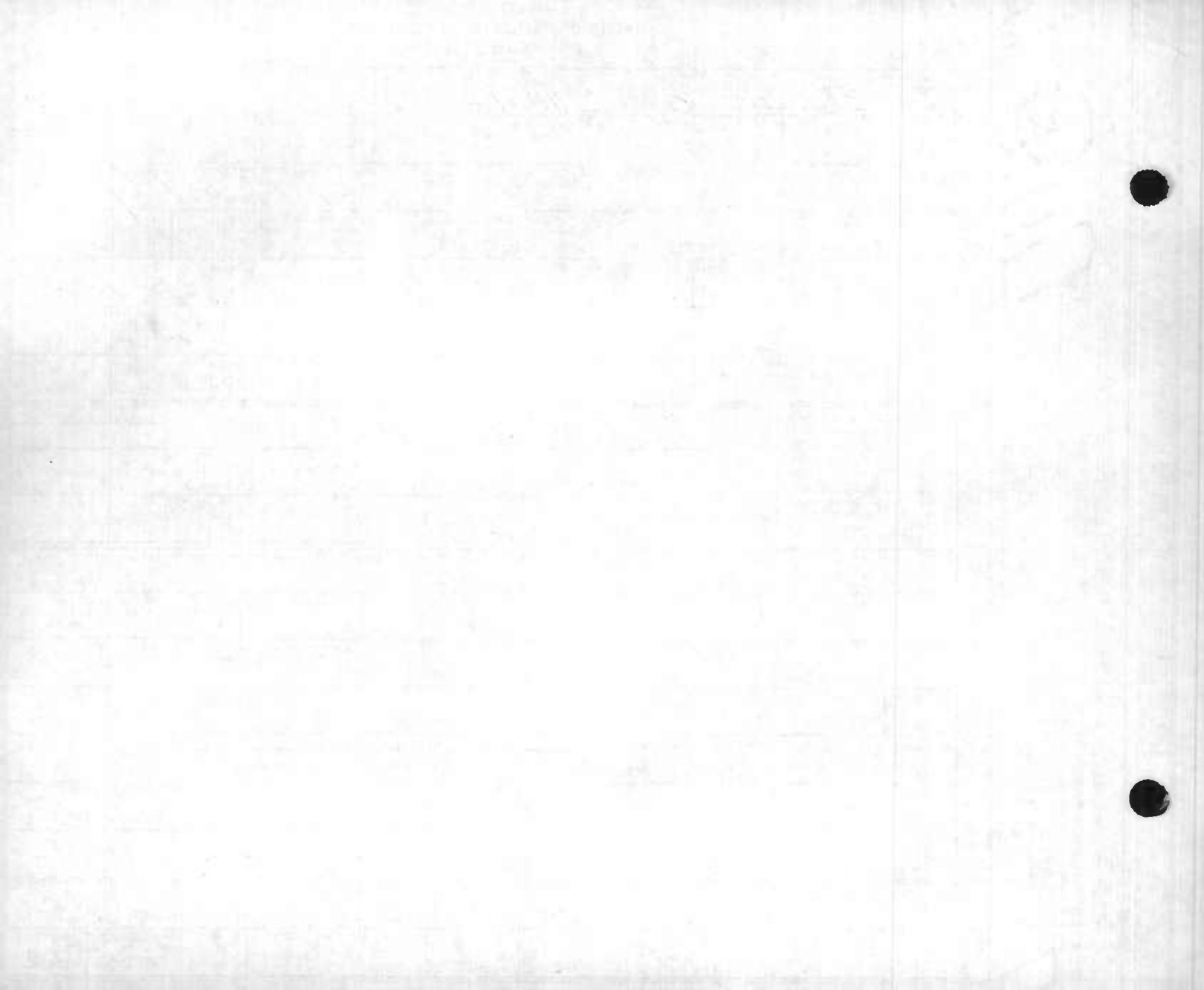
1. FOR  
STATE  
REGISTRAR

|  |  |  |   |  |                            |  |
|--|--|--|---|--|----------------------------|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br><b>ELMER B. SMITH</b>   |  |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>1 26 85</b> |  | 2b. HOUR<br><b>8:15 PM</b> |  |
| 3 SEX<br><b>male</b>   |  | 4 RACE<br><b>black</b>   |   | 5 DATE OF BIRTH<br>MONTH DAY YEAR<br><b>8 12 49</b>                                    |                            |  |
| 6 AGE (IN YEARS LAST BIRTHDAY)<br><b>35</b> YRS  |  | 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Maryland</b>   |   | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>  |                            |  |
| 8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>   |  | 9 BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore City</b> MD  |   |  |                            |  |
| 10 CITY OR TOWN OF DEATH<br><b>Baltimore</b>   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Provident Hospital</b>                   |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)                       |                            |  |
| 12b. KIND OF BUSINESS OR INDUSTRY  |  | 13a. STATE<br><b>Maryland</b>  |   | 13b. COUNTY  |                            |  |
| 13c. CITY OR TOWN<br><b>Baltimore</b>  |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>  |   | 13e. STREET ADDRESS<br><b>1809 Clifton Ave 21217</b>                                   |                            |  |
| 14 FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Elmer T. Smith</b>   |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Doris Smith</b>  |   |  |                            |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>NO</b>  |  | 16b. SOCIAL SECURITY NO.<br><b>215-46-6977</b>   |   | 17. INFORMANT ADDRESS<br><b>Doris Smith 1809 Clifton Avenue</b>                        |                            |  |
| 18 CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)<br>PART 1. DEATH WAS CAUSED BY<br>IMMEDIATE CAUSE (a) <b>Respiratory/Cardiac Arrest</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <b>CARDIO-PULMONARY ARREST</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <b>PNEUMONIA</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last<br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |  |  |   |  |                            |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)<br><b>ALCOHOLISM</b>   |  |  |   |  |                            |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>              |                            |  |
| 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>   |  | 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER) |   | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19                             |                            |  |
| 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)   |  | 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  |   | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                 |                            |  |
| 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE  |  | 21g. LOCATION<br>STREET CITY OR TOWN COUNTY STATE  |   | 21h. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                      |                            |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>1/26</b> , 19 <b>85</b> , to <b>1/26</b> , 19 <b>85</b> , that (I) (we) last saw the deceased alive on <b>1/26</b> , 19 <b>85</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.   |  |  |   |  |                            |  |
| 22b. SIGNATURE<br><b>Sonetta G. Brown</b>  |  | DEGREE<br><b>MD</b>  |   | 22c. DATE SIGNED<br><b>1/26/85</b>   |                            |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>DR. A. UBEROI</b>  |  | 22e. ADDRESS<br><b>2600 Liberty Heights</b>  |   |  |                            |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>SPECIES<br><b>BURIAL</b>  |  | 23b. DATE<br><b>1/31/85</b>  |   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Cedar Hill Cemetery Anne Arundel Co., Md.</b> |                            |  |
| 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Baltimore City MD</b>   |  | 23e. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Baltimore City MD</b>   |   | 23f. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Baltimore City MD</b>                 |                            |  |
| 24 FUNERAL DIRECTOR<br>NAME<br><b>Wm C March F/H Inc.</b>  |  | ADDRESS<br><b>1101 E North Avenue</b>  |   | 25a. DATE REC'D BY REGISTRAR<br><b>JAN 29 1985</b>                                     |                            |  |
| 25b. REGISTRAR'S SIGNATURE<br><b>Julia Davidson-Rendall</b>  |  |  |   |  |                            |  |

TO HOSPITAL OR ATTENDING PHYSICIAN The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 4 should be detached for use as the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified by phone.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

85 01551

FOR  
1- STATE  
REGISTRAR

REG. NO.

|   |                         |  |  |   |                             |
|---|-------------------------|--|--|---|-----------------------------|
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>FREDERICK W. SMITH</b>   |                         |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>01 06 85</b> |   | 2b. HOUR<br><b>6:30 A M</b> |
| 3. SEX<br><b>MALE</b>   | 4. RACE<br><b>WHITE</b> | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>APRIL 17, 1907</b>  |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>77</b> YRS.   |                             |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>PENNSYLVANIA</b>  |                         | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>  |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore city</b> MD.                               |                             |
| 10. CITY OR TOWN OF DEATH<br><b>city</b>  |                         | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>BON SECOURS HOSPITAL</b> |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>WELDER</b>               |                             |
| 12b. KIND OF BUSINESS OR INDUSTRY<br><b>CONSTRUCTION</b>  |                         |  |  |   |                             |
| 13a. STATE<br><b>MARYLAND</b>   |                         | 13b. CITY OR TOWN<br><b>21224</b>  | 13c. CITY OR TOWN<br><b>BALTIMORE</b>                  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |                             |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>FRANK SMITH</b>  |                         | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>ESTELLA PENDLEBERRY</b>  |  |   |                             |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>YES</b>  |                         | 16b. SOCIAL SECURITY NO.<br><b>1926-1926</b>   |  | 17. INFORMANT<br>ADDRESS<br><b>FAYE E. KILGORE 39 S. ELLWOOD AVE. 21224</b>                     |                             |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Bilateral pneumonia</b><br>DUE TO, OR AS A CONSEQUENCE OF (b) <b>Arterio Sclerotic cardiovascular disease</b><br>DUE TO, OR AS A CONSEQUENCE OF (c) <b>Senile dementia</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. |                         |  |  |   |                             |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)  |                         |  |  |   |                             |
| 19a. DATE OF OPERATION  |                         | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>                       |                             |
| 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>  |                         |  |  |   |                             |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER NOTIFY MEDICAL EXAMINER)  |                         | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)                   |                             |
| 21d. INJURY OCCURRED<br>WHITE <input type="checkbox"/> NOT WHITE <input type="checkbox"/><br>AT WORK <input type="checkbox"/> AT HOME <input type="checkbox"/>  |                         | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |                             |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>12/31</b> , 19 <b>84</b> , to <b>1/6</b> , 19 <b>85</b> , that (I) (we) last saw the deceased alive on <b>1/6</b> , 19 <b>85</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.   |                         |  |  |   |                             |
| 22b. SIGNATURE<br><b>Kuang-Yen Huang M.D.</b>   |                         | DEGREE<br><b>M.D.</b>  |  | 22c. DATE SIGNED<br><b>1/6/85</b>   |                             |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>KUANG-YEN HUANG</b>   |                         | 22e. ADDRESS<br><b>BON SECOURS Hospital</b>  |  |   |                             |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>BURIAL</b>  |                         | 23b. DATE<br><b>JAN. 9, '85</b>  |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>MORELAND MEM. PARK</b>                                 |                             |
| 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>BALTIMORE CO., MD</b>  |                         | 25a. DATE REC'D. BY REGISTRAR<br><b>JAN 8 1985</b>   |  |   |                             |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>WILLIAM E. JOHNSON</b>   |                         | ADDRESS<br><b>8521 LOCH RAVEN BLVD.</b>  |  | 25b. REGISTRAR'S SIGNATURE<br><b>John Davidson-Randall</b>                                      |                             |

BP

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1. *Journal of the American Medical Association*, 1990; 263: 1025-1026.

1- STATE  
REGISTRAR

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

|   |  |        |        |   |  |   |  |  |      |                  |  |   |  |  |          |                                   |  |  |  |
|---|--|--------|--------|---|--|---|--|--|------|------------------|--|---|--|--|----------|-----------------------------------|--|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)   |  |        | FIRST  |   |  | MIDDLE  |  |  | LAST |                  |  | 7a. DATE KNOWN OF DEATH   |  |  | 7b. HOUR |                                   |  |  |  |
| Lawrence  |  |        | Harold |   |  | Smith   |  |  |      |                  |  | MONTH DAY YEAR  |  |  | 1 5 1985 |                                   |  |  |  |
| 3 SEX   |  | 4 RACE |        | 5 DATE OF BIRTH   |  | 6 AGE (IN YEARS LAST BIRTHDAY)                              |  | IF UNDER 1 YR.   |      | IF UNDER 24 HRS. |  | 7c. DATE PRONOUNCED DEAD  |  |  | 7d. HOUR |                                   |  |  |  |
| Male  |  | White  |        | MONTH DAY YEAR  |  | YRS.  |  | MONTHS   |      | DAYS             |  | MONTH DAY YEAR  |  |  | 11:12    |                                   |  |  |  |
| BIRTHPLACE (STATE OR FOREIGN COUNTRY)   |  |        |        | 7b. CITIZEN OF WHAT COUNTRY?  |  |   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |      |                  |  | 9. BALTIMORE CITY OR COUNTY OF DEATH  |  |  |          |                                   |  |  |  |
| Maryland  |  |        |        | U.S.A.  |  |   |  |  |      |                  |  | Baltimore City, MD.   |  |  |          |                                   |  |  |  |
| 10. CITY OR TOWN OF DEATH   |  |        |        | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) |  |   |  |  |      |                  |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)                 |  |  |          | 12b. KIND OF BUSINESS OR INDUSTRY |  |  |  |
| Baltimore   |  |        |        | 2030 Wilkens Avenue   |  |   |  |  |      |                  |  | Baker   |  |  |          | Bakery (A&P)                      |  |  |  |
| 13a. STATE  |  |        |        | 13b. COUNTY   |  |   |  | 13c. CITY OR TOWN  |      |                  |  | 13d. INSIDE CITY LIMITS?  |  | 13e. STREET ADDRESS                          |          |                                   |  |  |  |
| Maryland  |  |        |        |   |  |   |  | Baltimore  |      |                  |  | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>           |  | 2030 Wilkens Avenue 21223                    |          |                                   |  |  |  |
| 14. FATHER'S NAME   |  |        |        |   |  | 15. MOTHER'S MAIDEN NAME                                    |  |  |      |                  |  |   |  |  |          |                                   |  |  |  |
| FIRST MIDDLE LAST   |  |        |        |   |  | FIRST MIDDLE LAST   |  |  |      |                  |  |   |  |  |          |                                   |  |  |  |
| William   |  |        |        |   |  | Smith   |  |  |      |                  |  | Virginia Hope   |  |  |          |                                   |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)  |  |        |        |   |  | 16b. SOCIAL SECURITY NO.                                    |  |  |      |                  |  | 17. INFORMANT ADDRESS   |  |  |          |                                   |  |  |  |
| NO  |  |        |        |   |  | 219-14-0639   |  |  |      |                  |  | Josephine C. Battaglia 3627 Hooper Rd. 21776                                  |  |  |          |                                   |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)   |  |        |        |   |  |   |  |  |      |                  |  |   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |          |                                   |  |  |  |
| PART 1 DEATH WAS CAUSED BY:   |  |        |        |   |  |   |  |  |      |                  |  |   |  |  |          |                                   |  |  |  |
| IMMEDIATE CAUSE (a) Acute quinine intoxication  |  |        |        |   |  |   |  |  |      |                  |  |   |  |  |          |                                   |  |  |  |
| DUE TO, OR AS A CONSEQUENCE OF  |  |        |        |   |  |   |  |  |      |                  |  |   |  |  |          |                                   |  |  |  |
| Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.   |  |        |        |   |  |   |  |  |      |                  |  |   |  |  |          |                                   |  |  |  |
| (b) DUE TO, OR AS A CONSEQUENCE OF  |  |        |        |   |  |   |  |  |      |                  |  |   |  |  |          |                                   |  |  |  |
| (c)   |  |        |        |   |  |   |  |  |      |                  |  |   |  |  |          |                                   |  |  |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1  |  |        |        |   |  |   |  |  |      |                  |  |   |  |  |          |                                   |  |  |  |
| 19a. DATE OF OPERATION  |  |        |        |   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?           |  |  |      |                  |  | 20. AUTOPSY?  |  |  |          |                                   |  |  |  |
|   |  |        |        |   |  |   |  |  |      |                  |  | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>           |  |  |          |                                   |  |  |  |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH  |  |        |        |   |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR                |  |  |      |                  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) |  |  |          |                                   |  |  |  |
|   |  |        |        |   |  | P.M. 1/5 1985   |  |  |      |                  |  | ingested quinine  |  |  |          |                                   |  |  |  |
| 21d. INJURY OCCURRED WHILE AT WORK <input checked="" type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>   |  |        |        |   |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) |  |  |      |                  |  | 21f. LOCATION   |  |  |          |                                   |  |  |  |
|   |  |        |        |   |  | home  |  |  |      |                  |  | 2030 Wilkens Ave. Baltimore, Md.  |  |  |          |                                   |  |  |  |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: <input checked="" type="checkbox"/> Accidents <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input checked="" type="checkbox"/> |  |        |        |   |  |   |  |  |      |                  |  |   |  |  |          |                                   |  |  |  |
| ACTUAL SIGNATURE  |  |        |        |   |  | TITLE (SPECIFY)   |  |  |      |                  |  | DATE SIGNED   |  |  |          |                                   |  |  |  |
| Thomas D. Smith, M.D.   |  |        |        |   |  | M.D. Acting Chief   |  |  |      |                  |  | 1/6/85  |  |  |          |                                   |  |  |  |
| EXAMINER'S NAME (TYPE OR PRINT)   |  |        |        |   |  | ADDRESS   |  |  |      |                  |  |   |  |  |          |                                   |  |  |  |
| Thomas D. Smith, M.D.   |  |        |        |   |  | 111 Penn St. Balto., MD.                                    |  |  |      |                  |  |   |  |  |          |                                   |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)   |  |        |        | 23b. DATE   |  |   |  | 23c. NAME OF CEMETERY OR CREMATORY   |      |                  |  | 23d. LOCATION   |  |  |          |                                   |  |  |  |
| Burial  |  |        |        | 1/9/85  |  |   |  | Crestlawn Gardens of Mem.  |      |                  |  | CITY OR TOWN COUNTY STATE   |  |  |          |                                   |  |  |  |
|   |  |        |        |   |  |   |  | Howard   |      |                  |  | Md.   |  |  |          |                                   |  |  |  |
| 24. FUNERAL DIRECTOR NAME   |  |        |        |   |  | 25a. DATE REC'D. BY REGISTRAR                               |  |  |      |                  |  | 25b. REGISTRAR'S SIGNATURE  |  |  |          |                                   |  |  |  |
| Hubbard Funeral Home, Inc.  |  |        |        |   |  | 21229 4107 Wilkens Ave.                                     |  |  |      |                  |  | JAN 9 1985  |  |  |          |                                   |  |  |  |

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 ON YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED. 24 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201





STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 5 0 1 5 5 3

FOR  
1 - STATE  
REGISTRAR

REG. NO.

|  |  |  |  |  |  |  |   |
|--|--|--|--|--|--|--|---|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>LEROY L Smith   |  |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br>1 30 85                                 |  |  | 2b. HOUR<br>1600 M   |   |
| 3. SEX<br>M  |  | 4. RACE<br>B   |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>1 9 29   |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br>56<br>YRS.                                    |   |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>md.   |  | 7b. CITIZEN OF WHAT COUNTRY?<br>USA  |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>BALTO. CITY MD.                          |   |
| 10. CITY OR TOWN OF DEATH<br>BALTIMORE   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>UNIVERSITY HOSP. MIEMSS |  |  |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>CONSTRUCTION |   |
| 13a. STATE<br>md.  |  |  |  | 13b. COUNTY<br>BALTO.  |  | 13c. CITY OR TOWN<br>Cockeysville  |   |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>LeRoy A Smith  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>ARDella Powell  |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>  |  |  |   |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br>NO   |  | 16b. SOCIAL SECURITY NO.<br>213-26-1001  |  | 17. INFORMANT<br>ADDRESS<br>MARVIN Smith 15809 YEOP RD. SPARKS MD.   |  |  |   |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>8880 IMMEDIATE CAUSE (a) Respiratory Arrest<br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) Adult Respiratory Distress<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) Closed Head Injury<br>APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH |  |  |  |  |  |  |   |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: a  |  |  |  |  |  |  |   |
| 19a. DATE OF OPERATION   |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                               |  |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>        |   |
| 20b. IF YES, WERE FINDINGS USED<br>IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>  |  |  |  |  |  |  |   |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 1 22 85                |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)<br>found on floor |  |   |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/><br>AT WORK AT WORK  |  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)<br>Home |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE<br>14419 FALLS Road, Baltimore County MD       |  |   |
| 22a. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did not) view the body after death.   |  |  |  |  |  |  |   |
| 22b. SIGNATURE<br>[Signature]  |  |  | 22c. DATE SIGNED<br>1/30/85  |  |  | 22d. PHYSICIAN'S NAME<br>Daniel L. Herr MD                                       |   |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br>BURIAL   |  |  | 23b. DATE<br>2/2/85  |  | 23c. NAME OF CEMETERY OR CREMATORY<br>Gough Yh ch Cem  |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Cockeysville MD |
| 24. FUNERAL DIRECTOR<br>NAME<br>CHATMAN-HARRIS FH  |  |  |  | 25. DATE REC'D. BY REGISTRAR<br>FEB 6 1985   |  | 25b. REGISTRAR'S SIGNATURE<br>[Signature]  |   |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 2 should be filed within 22 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked as "B" above, it is subject to autopsy, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

BP



STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 5 0 1 5 5 4

1. FOR  
STATE  
REGISTRAR

REG. NO.

|   |  |  |  |  |                            |  |
|---|--|--|--|--|----------------------------|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>FIRST MIDDLE LAST<br><i>Lucille NMI Smith</i>  |  |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><i>Jan 23 1985</i>  |  | 2b. HOUR<br><i>0750 AM</i> |  |
| 3. SEX<br><i>Female</i>   |  | 4. RACE<br><i>Black</i>  |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><i>11 16 09</i>  |                            |  |
| 6. AGE (IN YEARS LAST BIRTHDAY)<br><i>75</i> YRS.   |  | 7. UNDER 1 YEAR<br>MONTHS DAYS<br><i>0 0</i>                           |  | 8. UNDER 24 HRS.<br>HOURS MIN.<br><i>0 0</i>   |                            |  |
| 7a. BIRTHPLACE<br>COUNTRY<br><i>VA</i>  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><i>USA</i>                             |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |                            |  |
| 9. BALTIMORE CITY OR COUNTY OF DEATH<br><i>Balto City</i> MD.   |  |  | 10. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><i>Retired American Masonry</i> |  |                            |  |
| 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET AND CITY)<br><i>Un. vers. of Maryland Hospal</i> |  |  | 12. KIND OF BUSINESS OR INDUSTRY<br><i>20785</i>   |  |                            |  |
| 13a. STATE<br><i>MD</i>   |  | 13b. COUNTY<br><i>Pa-georges</i>                                       |  | 13c. CITY OR TOWN<br><i>Landover</i>   |                            |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><i>John N. Richardson</i>   |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><i>Condelia Davis</i> |  |  |                            |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><i>UNK</i>  |  | 16b. SOCIAL SECURITY NO.<br><i>577-30-658</i>                          |  | 17. INFORMANT<br>ADDRESS   |                            |  |

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).  
PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a)

*cardiac arrest*

DUE TO, OR AS A CONSEQUENCE OF

(b)

*sepsis*

DUE TO, OR AS A CONSEQUENCE OF

(c)

APPROXIMATE INTERVAL  
BETWEEN ONSET AND DEATH

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)

*coagulopathy, renal failure*

|   |  |   |  |   |  |
|---|--|---|--|---|--|
| 19a. DATE OF OPERATION<br><i>1/14/85</i>  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED<br><i>rectal bleeding, hypopharynx</i> |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 20b. IF YES, WERE FINDINGS USED<br>IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>   |  | 21a. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><i>12/10 19 85</i>                   |  |   |  |
| 21b. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)<br><i>19</i>   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)          |  |   |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK   |  | 21e. LOCATION<br>STREET CITY OR TOWN COUNTY STATE<br><i>22 S. Greene St Balto 21201</i> |  |   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <i>12/10</i> 19 <i>85</i> to <i>1/23</i> 19 <i>85</i> , that (I) (we) lost<br>saw the deceased alive on <i>1/23</i> 19 <i>85</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated<br>above, (I) (we) (did) (did not) view the body after death. |  |   |  |   |  |
| 22b. SIGNATURE<br><i>Robert Reid MD</i>   |  | DEGREE<br><i>MD</i>   |  | 22c. DATE SIGNED<br><i>1/23/85</i>  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><i>Robert Reid</i>   |  | 22e. ADDRESS<br><i>22 S. Greene St Balto 21201</i>                                      |  |   |  |

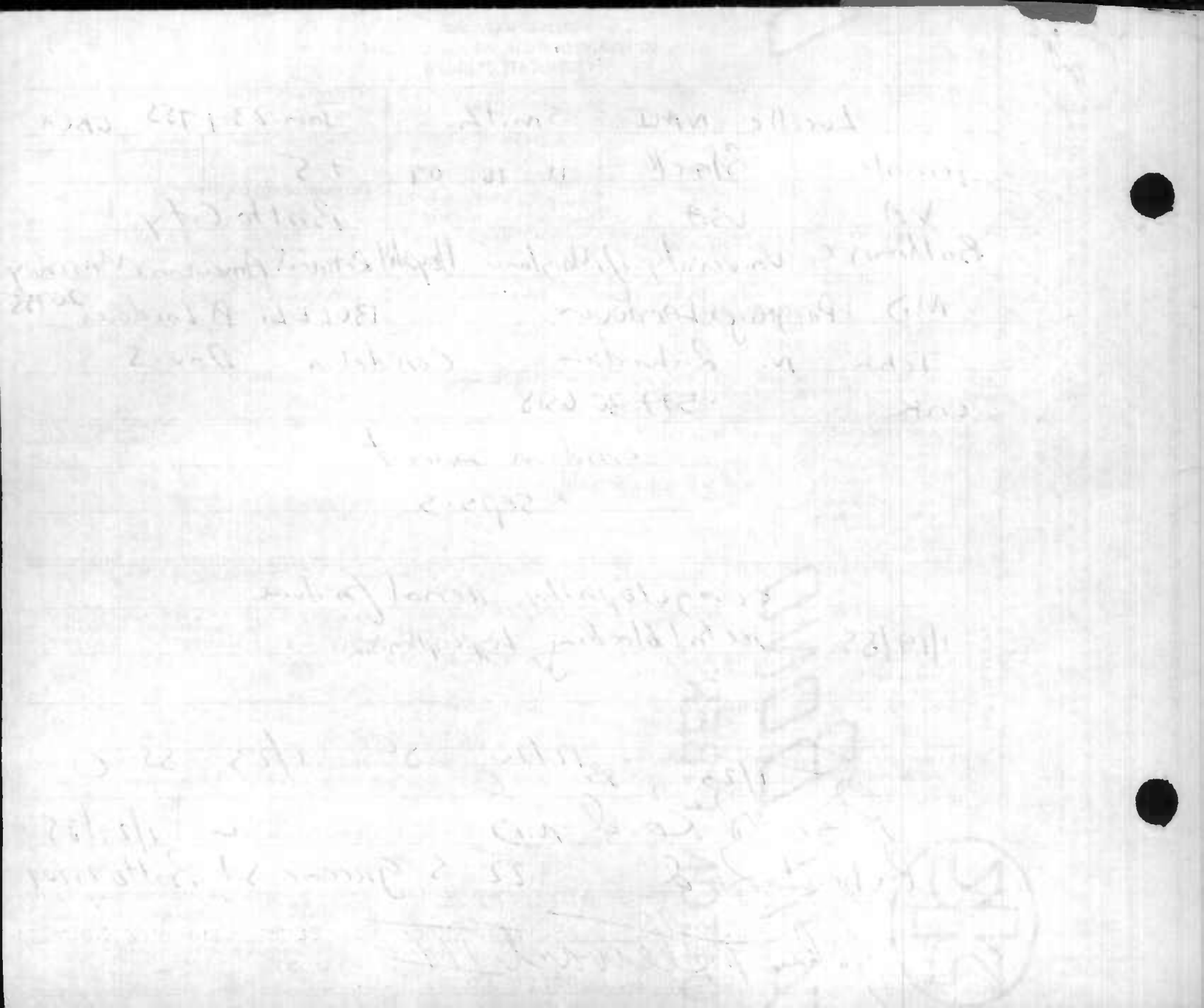
|   |  |  |  |  |  |   |  |
|---|--|--|--|--|--|---|--|
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><i>Burial</i> |  | 23b. DATE<br><i>Jan. 25, 1985</i>                  |  | 23c. NAME OF CEMETERY OR CREMATORY<br><i>Harmony Memorial Park</i> |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><i>Landover, Maryland</i> |  |
| 24. FUNERAL DIRECTOR<br>NAME<br><i>Stewart</i>                |  | 25. DATE REC'D. BY REGISTRAR<br><i>JAN 30 1985</i> |  | 26. REGISTRAR'S SIGNATURE<br><i>Condelia Davis</i>                 |  |   |  |

BP \_\_\_\_\_

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked as item 18, any injury, or other traumatic event, the medical examiner must be notified at once.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH  |  |  |  | REG. NO.  |  |  |  |
|---|--|--|--|---|--|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>MAGGIE C. Smith</b>  |  |  |  | 20. DATE OF DEATH<br>MONTH DAY YEAR<br><b>1/2/85</b>  |  |  |  |
| 3. SEX<br><b>Female</b>   |  | 4. RACE<br><b>Black</b>  |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>5 30 1911</b>  |  | 26. HOUR<br><b>445 PM</b>  |  |
| 70. BIRTHPLACE<br>(STATE OR FOREIGN COUNTRY)<br><b>N. Carolina</b>  |  | 76. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore City, MD.</b>   |  |
| 10. CITY OR TOWN OF DEATH<br><b>Baltimore City</b>  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Melchor Nursing Home</b> |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>domestic</b>   |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>N/A</b>  |  |
| 13a. STATE<br><b>Maryland</b>   |  | 13b. COUNTY<br><b>Baltimore</b>  |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>   |  | 13e. STREET ADDRESS / ZIP CODE<br><b>2327 N. Charles St. 21218</b>   |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>John Corbett</b>   |  |  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Maggie Carr</b>   |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) <b>NO</b>  |  | 16b. SOCIAL SECURITY NO.<br><b>231-09-6140</b>   |  | 17. INFORMANT<br>ADDRESS<br><b>Melchor Nursing Home 2327 N. Charles St. 21218</b>   |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for 18a, (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>respiratory arrest</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last<br>(b) <b>organic brain syndrome</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <b>ASCVD</b> |  |  |  |   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH   |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)  |  |  |  |   |  |  |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>   |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>10</b> , 19 <b>81</b> , to <b>12</b> , 19 <b>84</b> , that (we) last saw the deceased alive on <b>12/27</b> , 19 <b>84</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.                             |  |  |  |   |  |  |  |
| 22b. SIGNATURE<br><b>M. Shaboky</b>   |  | DEGREE<br><b>ATTENDING PHYSICIAN</b>   |  | 22c. DATE SIGNED<br><b>1/3/85</b>   |  | 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>Melvin Shaboky</b>   |  |
| 22e. ADDRESS<br><b>353 St. Pauli Pl. Suite 6C. 21218</b>  |  |  |  |   |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>Burial</b>   |  | 23b. DATE<br><b>1/7/85</b>   |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Arbutus Mem. Pk.</b>   |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Arbutus Md.</b>   |  |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>Wm. C. March F/H 1101 E. North Ave.</b>  |  |  |  | 25a. DATE REC'D. BY REGISTRAR<br><b>JAN 4 1985</b>  |  |  |  |

244

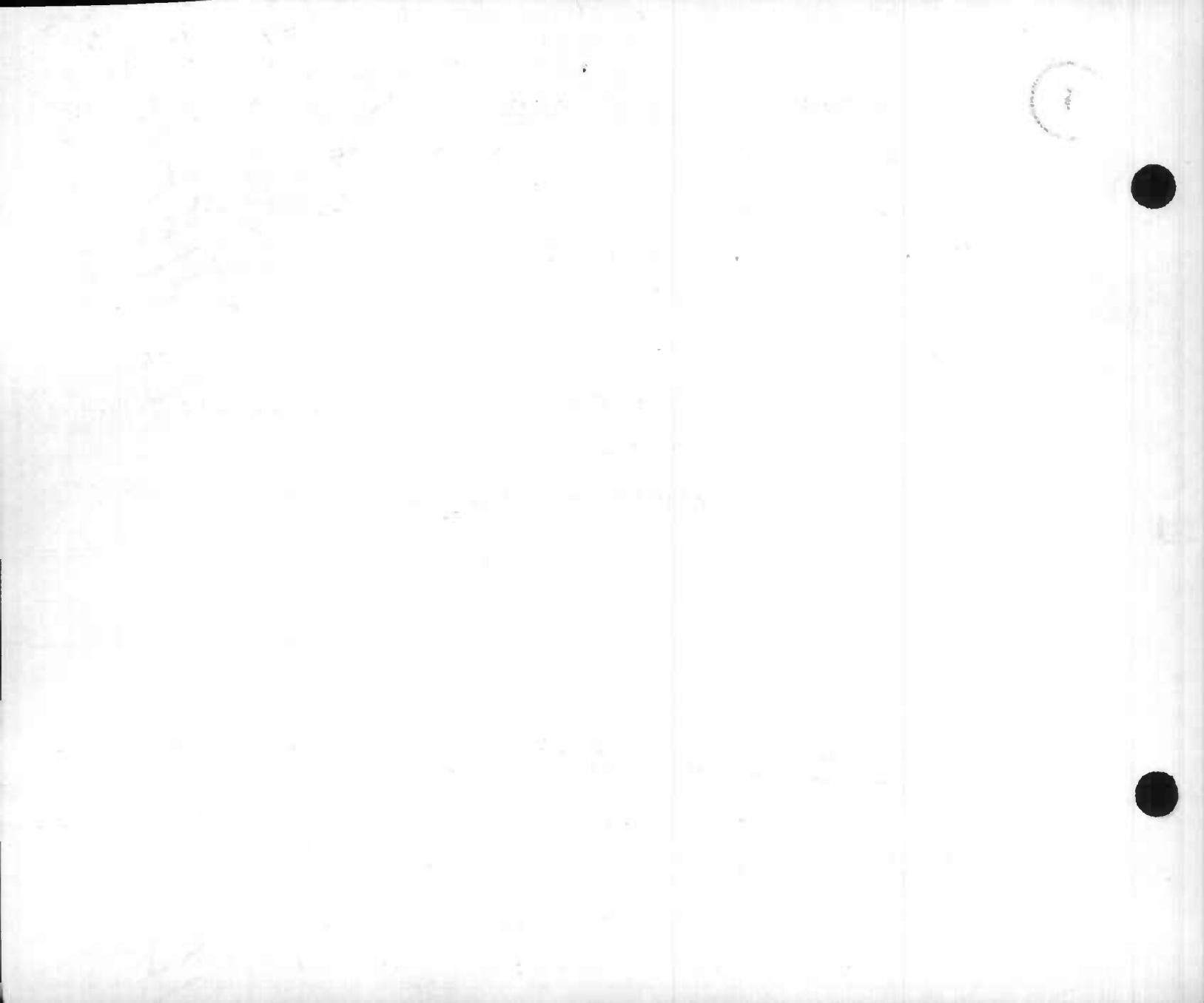


TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours of death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH  |  |  |  |  |  |   |  |                                |  |
|---|--|--|--|--|--|---|--|--------------------------------|--|
| 1. FOR STATE REGISTRAR  |  | 2a. DATE OF DEATH  |  | MONTH DAY YEAR   |  | 2b. HOUR  |  | a                              |  |
| 1. DECEASED NAME (TYPE OR PRINT)  |  | FIRST MIDDLE LAST  |  | 1 23 85  |  | 03:55   |  | M                              |  |
| Marie Smith   |  |  |  |  |  |   |  |                                |  |
| 3. SEX  |  | 4. RACE  |  | 5. DATE OF BIRTH   |  | 6. AGE (IN YEARS LAST BIRTHDAY)                                     |  | 7. IF UNDER 1 YEAR             |  |
| Female  |  | Negro  |  | 12 18 15   |  | 69  |  | MONTHS DAYS HOURS MIN.         |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)   |  | 7b. CITIZEN OF WHAT COUNTRY?   |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH                                |  |                                |  |
| Balto. Md.  |  | USA  |  |  |  | Baltimore City  |  | MD.                            |  |
| 10. CITY OR TOWN OF DEATH   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)  |  | 12b. KIND OF BUSINESS OR INDUSTRY                                   |  |                                |  |
| Balt. City  |  | St. Agnes Hospital   |  |  |  |   |  |                                |  |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)  |  | 13b. COUNTY  |  | 13c. CITY OR TOWN  |  | 13d. INSIDE CITY LIMITS?  |  | 13e. STREET ADDRESS / ZIP CODE |  |
| Md  |  |  |  | Balt   |  | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 820 S Caton Ave 21229          |  |
| 14. FATHER'S NAME   |  | 15. MOTHER'S MAIDEN NAME   |  |  |  |   |  |                                |  |
| FIRST MIDDLE LAST   |  | FIRST MIDDLE LAST  |  |  |  |   |  |                                |  |
| Henry Marshall  |  | Viola Cornish  |  |  |  |   |  |                                |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)   |  | 16b. SOCIAL SECURITY NO.   |  | 17. INFORMANT  |  | ADDRESS   |  |                                |  |
| No  |  | 213-28-4366  |  | Archie Smith   |  | 820 S. Caton Ave  |  |                                |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)   |  |  |  |  |  |   |  |                                |  |
| PART 1. DEATH WAS CAUSED BY:  |  |  |  |  |  |   |  |                                |  |
| IMMEDIATE CAUSE (a) <u>Coronary Artery</u>  |  |  |  |  |  |   |  |                                |  |
| DUE TO, OR AS A CONSEQUENCE OF  |  |  |  |  |  |   |  |                                |  |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost   |  |  |  |  |  |   |  |                                |  |
| (b) <u>Hypertension - Hypertensive Heart Disease</u>  |  |  |  |  |  |   |  |                                |  |
| DUE TO, OR AS A CONSEQUENCE OF  |  |  |  |  |  |   |  |                                |  |
| (c) <u>254rt</u>  |  |  |  |  |  |   |  |                                |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:  |  |  |  |  |  |   |  |                                |  |
|   |  |  |  |  |  |   |  |                                |  |
| MEDICAL CERTIFICATION   |  |  |  |  |  |   |  |                                |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  | 20a. AUTOPSY?  |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?      |  |                                |  |
|   |  |  |  | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  | YES <input type="checkbox"/> NO <input type="checkbox"/>            |  |                                |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)   |  |   |  |                                |  |
|   |  | HOUR A.M. MONTH DAY YEAR   |  |  |  |   |  |                                |  |
|   |  | P.M. 19  |  |  |  |   |  |                                |  |
| 21d. INJURY OCCURRED  |  | 21e. PLACE OF INJURY   |  | 21f. LOCATION  |  |   |  |                                |  |
| WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>   |  | (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |  | STREET   |  | CITY OR TOWN  |  | COUNTY STATE                   |  |
| AT WORK   |  |  |  |  |  |   |  |                                |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>3-26</u> , 19 <u>83</u> , to <u>1-23</u> , 19 <u>85</u> , that (I) (we) last saw the deceased alive on <u>12-12</u> , 19 <u>84</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (not) view the body after death. |  |  |  |  |  |   |  |                                |  |
| 22b. SIGNATURE  |  | DEGREE   |  | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>               |  | 22c. DATE SIGNED  |  |                                |  |
| <u>C. R. Davidson M.D.</u>  |  | M.D.   |  |  |  | 1-23-85   |  |                                |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)   |  | 22e. ADDRESS   |  |  |  |   |  |                                |  |
| <u>Charles R. Davidson, M.D.</u>  |  | <u>2034 W. North Ave</u>   |  | <u>Baltimore</u>   |  | <u>21217</u>  |  |                                |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)   |  | 23b. DATE  |  | 23c. NAME OF CEMETERY OR CREMATORY   |  | 23d. LOCATION   |  | STATE                          |  |
| Burial  |  | 1/28/85  |  | Arbutus Mem. Pk.   |  | Baltimore Co.   |  | MD                             |  |
| 24. FUNERAL DIRECTOR  |  |  |  | 25. DATE REGD. BY REGISTRAR  |  | 26. REGISTRAR'S SIGNATURE   |  |                                |  |
| NAME ADDRESS  |  |  |  | JAN 25 1985  |  | <u>John Davidson</u>  |  |                                |  |
| Wm. C. March F/H 1101 E. North Ave.   |  |  |  |  |  |   |  |                                |  |



**STATE OF MARYLAND**  
**DEPARTMENT OF HEALTH AND MENTAL HYGIENE**  
**CERTIFICATE OF DEATH**

8 5 0 1 5 5 7

FOR  
 1 - STATE  
 REGISTRAR

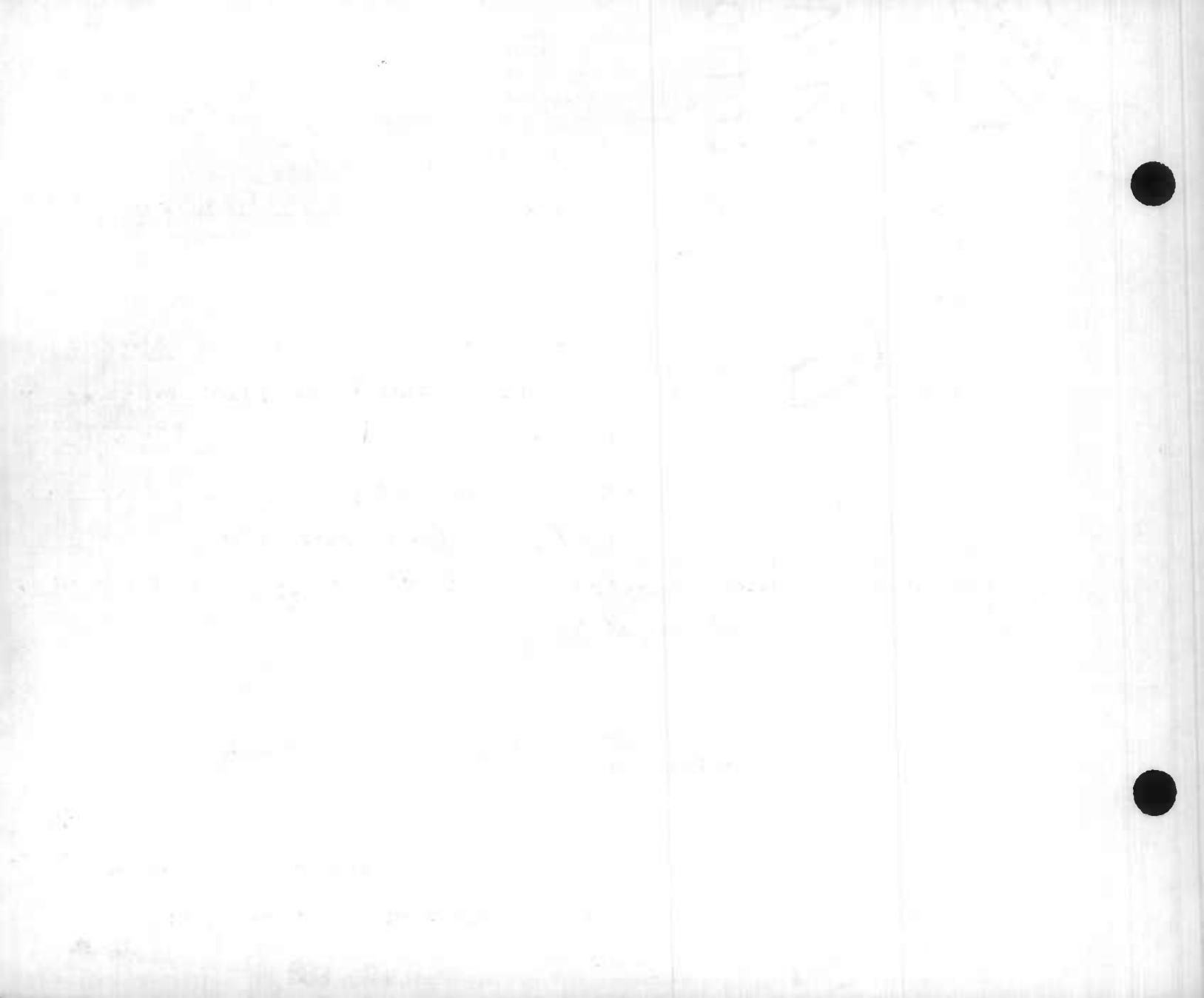
REG. NO.

|   |   |   |   |   |   |
|---|---|---|---|---|---|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>ROBERT A SMITH   |   |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br>1 22 85  |   | 2b. HOUR<br>6:57 AM   |
| 3. SEX<br>M   | 4. RACE<br>B  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>4 12 12   | 6. AGE (IN YEARS LAST BIRTHDAY)<br>72 YRS.  | IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS.<br>HOURS MIN.  |   |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>MARYLAND   | 7b. CITIZEN OF WHAT COUNTRY?<br>USA   | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>CITY, Baltimore MD.   |   |   |
| 10. CITY OR TOWN OF DEATH<br>BALTIMORE  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>BON SEOURS HOSP. |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)  | 12b. KIND OF BUSINESS OR INDUSTRY   |   |
| 13a. STATE<br>Md  |   |   | 13b. COUNTY<br>Baltimore  | 13c. CITY OR TOWN<br>Baltimore  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |
| 13e. STREET ADDRESS / ZIP CODE<br>701 N. ARLINGTON ST. 21217  |   |   | 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>JAMES SMITH   |   |   |
| 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>ROSIE ELLA BRISCOE   |   |   | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)<br>Yes |   |   |
| 16b. SOCIAL SECURITY NO.<br>093-12-1717   |   |   | 17. INFORMANT<br>ADDRESS<br>Eldora Christopher 1215 Mosher St   |   |   |
| 18. CAUSE OF DEATH: Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) Multiple<br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) Renal Failure<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) COLD + Pneumonia   |   |   |   |   | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH<br>± 4-5 days<br>Chronic                        |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)<br>Volume Overload, Hyperkalemia, GI Bleeding, Pulm. Edema.   |   |   |   |   |   |
| 19a. DATE OF OPERATION<br>1/6/85  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED<br>Cholecystitis   |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                    | 20b. IF YES, WERE FINDINGS USED<br>IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |   |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)  |   |   |   |
| 21d. INJURY OCCURRED<br>AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>   | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |   |   |   |
| 22a. I certify that (I) (this hospital) attended the deceased from 1/1/85 19 to 1/22 1985, that (I) (we) last saw the deceased alive on 1/22 1985, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |   |   |   |   |   |
| 22b. SIGNATURE<br>S.S. DANG M.D.  |   | DEGREE<br>M.D.  |   | 22c. DATE SIGNED<br>1/22/85   |   |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>S.S. DANG M.D.   |   | 22e. ADDRESS<br>40. DUNDALK AVE Baltimore MD 21222  |   |   |   |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br>Burial  | 23b. DATE<br>1/24/85  | 23c. NAME OF CEMETERY OR CREMATORY<br>Garrison Forest VA  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Owings Mills MD   |   |   |
| 24. FUNERAL DIRECTOR<br>NAME<br>Wm. C. March F/H 1101 E. North Ave.   |   |   | 25a. DATE REC'D. BY REGISTRAR<br>JAN 23 1985  |   |   |
|   |   |   | 25b. REGISTRAR'S SIGNATURE<br>John Davidson-Randall   |   |   |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. If the death occurs at home, the certificate must be signed by the attending physician and completely filled in by the funeral director. Pages 1 and 2 should be filed within 72 hours after death. The certificate must be retained by the hospital or attending physician. The law requires that the death certificate be executed within 24 hours after death. If the death occurs at home, the certificate must be signed by the attending physician and completely filled in by the funeral director. Pages 1 and 2 should be filed within 72 hours after death. The certificate must be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death. The certificate must be retained by the hospital or attending physician. The law requires that the death certificate be executed within 24 hours after death. If the death occurs at home, the certificate must be signed by the attending physician and completely filled in by the funeral director. Pages 1 and 2 should be filed within 72 hours after death. The certificate must be retained by the hospital or attending physician.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of once.





STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 5 0 1 5 5 8

1- FOR  
STATE  
REGISTRAR

REG. NO.

|  |  |   |  |                                   |   |
|--|--|---|--|-----------------------------------|---|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>ROBERT ROGER SMITH  |  |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br>29 1985                   |                                   | 2b. HOUR<br>9 P.M.  |
| 3. SEX<br>MALE   | 4. RACE<br>BLACK   | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>4 1 1905  | 6. AGE (IN YEARS LAST BIRTHDAY)<br>79 YRS.                       | IF UNDER 1 YEAR<br>MONTHS DAYS    | IF UNDER 24 HRS.<br>HOURS MIN.  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>USA-S. Car.   | 7b. CITIZEN OF WHAT COUNTRY?<br>USA  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>BALTIMORE CITY MD.       |                                   |   |
| 10. CITY OR TOWN OF DEATH<br>BALTIMORE   | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>University Hospital |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE) | 12b. KIND OF BUSINESS OR INDUSTRY |   |
| 13a. STATE<br>MARYLAND   |  |   | 13b. COUNTY<br>BALTIMORE   | 13c. CITY OR TOWN<br>BALTIMORE    | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>ROBERT SMITH   |  |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Lizzie Smith    |                                   |   |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)<br>UNKNOWN No |  | 16b. SOCIAL SECURITY NO.<br>250 321475  | 17. INFORMANT<br>ADDRESS<br>Lillie Smith 1500 Braddish Ave.      |                                   |   |

|   |  |   |
|---|--|---|
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) CARDIORESPIRATORY ARREST |  | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH<br>30 MINUTES |
| DUE TO, OR AS A CONSEQUENCE OF<br>(b) ATHEROSCLEROTIC HEART DISEASE   |  | 20 YEARS  |
| DUE TO, OR AS A CONSEQUENCE OF<br>(c) CHRONIC RENAL FAILURE   |  | 1 YEAR  |

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 11a

|   |  |  |   |
|---|--|--|---|
| 19a. DATE OF OPERATION  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                       | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>  | 20b. IF YES, WERE FINDINGS USED<br>IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER NOTIFY MEDICAL EXAMINER)   | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19             | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)   |   |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK   | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE  |   |
| 22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |  |  |   |
| 22b. SIGNATURE<br>Roman Kostrobiak  |  | DEGREE<br>ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> | 22c. DATE SIGNED<br>1/29/85   |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>ROMAN KOSTROBIAK   |  | 22e. ADDRESS<br>UNIVERSITY HOSPITAL, BALTIMORE, MD.  |   |

|  |                     |   |   |
|--|---------------------|---|---|
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br>Burial                 | 23b. DATE<br>2/2/85 | 23c. NAME OF CEMETERY OR CREMATORY<br>Arbuhus Mem. PK | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Balto., Md. |
| 24. FUNERAL DIRECTOR<br>NAME<br>Leroy O. Dyett 4600 Liberty Hgts. Ave. |                     | 25a. DATE REC'D. BY REGISTRAR<br>JAN 31 1985          |   |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages must be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked on item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

97 Jan 28

1-2-00

17



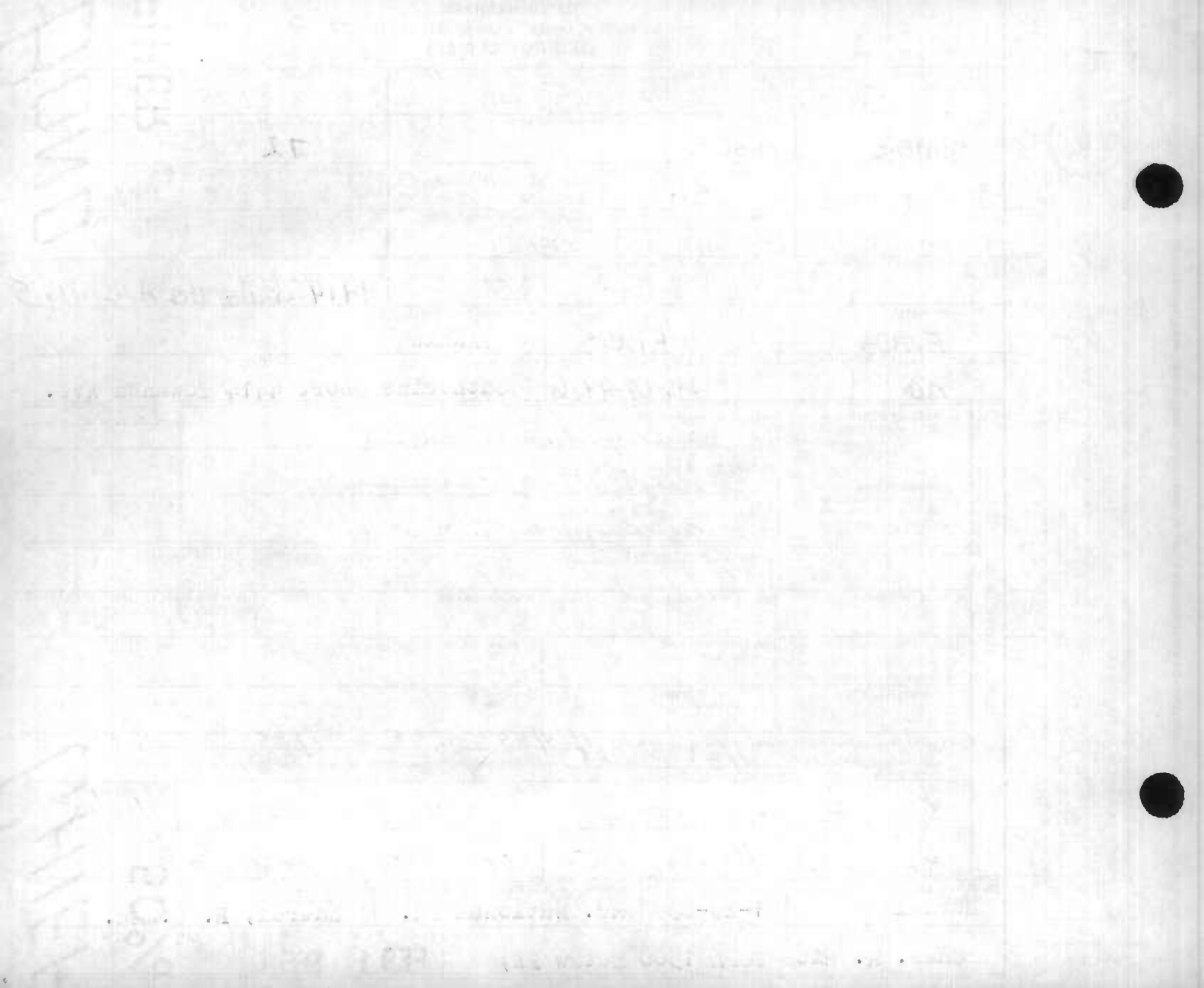
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Population be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.  
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH  |  |  |  | REG. NO. 8 5 0 1 5 5 9   |  |   |  |
|---|--|--|--|--|--|---|--|
| 1. FOR STATE REGISTRAR  |  |  |  | 2a. DATE OF DEATH MONTH DAY YEAR   |  |   |  |
| I. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST  |  |  |  | 2b. HOUR   |  |   |  |
| Sylvia SMITH  |  |  |  | 01 25 85 1 am  |  |   |  |
| 3. SEX  |  | 4. RACE  |  | 5. DATE OF BIRTH MONTH DAY YEAR  |  | 6. AGE (IN YEARS LAST BIRTHDAY) IF UNDER 1 YEAR IF UNDER 24 HRS   |  |
| female  |  | black  |  | 01 31 12   |  | 72 YRS. MONTHS DAYS HOURS MIN.  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)   |  | 7b. CITIZEN OF WHAT COUNTRY?   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>   |  | 9. BALTIMORE CITY OR COUNTY OF DEATH  |  |
| So. Carolina  |  | USA  |  |  |  | Baltimore City MD.  |  |
| 10. CITY OR TOWN OF DEATH   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)  |  | 12b. KIND OF BUSINESS OR INDUSTRY   |  |
| Balto   |  | Deaton Med. Center   |  |  |  |   |  |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)  |  | 13b. COUNTY  |  | 13c. CITY OR TOWN  |  | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                            |  |
| Md.   |  |  |  | Balto  |  | 13. STREET ADDRESS / ZIP CODE   |  |
| 14. FATHER'S NAME FIRST MIDDLE LAST   |  | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST   |  | 16. SOCIAL SECURITY NO.  |  |   |  |
| Evans   |  | Rivers   |  | 246-09-9916  |  |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)   |  | 17. INFORMANT ADDRESS  |  | 18. CAUSE OF DEATH (Enter only one cause per line for 1a), 1b), and 1c.)   |  |   |  |
| no  |  | Catherine Short 4414 Towanda Ave.  |  | PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Cardiopulmonary arrest</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last:<br>(b) <u>respiratory failure</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <u>airway obstruction</u><br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |  |   |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)  |  |  |  |  |  |   |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>   |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18. PART I OR PART 2)   |  |   |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>  |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                                    |  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE   |  |   |  |
| 22a. I certify that (I, (this hospital) attended the deceased from 1/24/85, 19 85, to 1/25, 19 85, that I (we) lost saw the deceased alive on 1/25, 19 85, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. I (we) (did) (did not) view the body after death. |  |  |  |  |  |   |  |
| 22b. SIGNATURE  |  | DEGREE   |  | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>   |  | 22c. DATE SIGNED  |  |
| Kenneth R. Coignet  |  |  |  |  |  | 1/25/85   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)   |  | 22e. ADDRESS   |  |  |  |   |  |
| KENNETH R. COIGNET  |  | 611 So. CHARLES ST.  |  |  |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL   |  | 23b. DATE  |  | 23c. NAME OF CEMETERY OR CREMATORY   |  | 23d. LOCATION CITY OR TOWN COUNTY STATE   |  |
| Burial  |  | 1-29-85  |  | Md. National PK.   |  | Laurel, P. G. Md.   |  |
| 24. FUNERAL DIRECTOR NAME Chas. A. Rice FSPA 1300 Eutaw Pl, ADDRESS   |  |  |  | 25a. DATE REC'D. BY REGISTRAR  |  | 25b. REGISTRAR'S SIGNATURE  |  |
|   |  |  |  | FEB 1 1985   |  | John Davidson-Randall   |  |





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page always be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 5 0 1 5 6 0

FOR  
1. STATE  
REGISTRAR

REG. NO.

|  |  |  |   |  |   |   |   |  |  |
|--|--|--|---|--|---|---|---|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>WILLIE L. SMITH</b>   |  |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>1 1 85</b>                  |  |   | 2b. HOUR<br><b>533 P.M.</b>   |   |  |  |
| 3. SEX<br><b>F</b>   |  | 4. RACE<br><b>N 2</b>  |   | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>12 25 17</b>  |   | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>67</b> YRS.                         |   | 7. IF UNDER 1 YEAR<br>MONTHS DAYS HOURS MIN.   |  |
| 7a. BIRTHPLACE<br>(STATE OR FOREIGN COUNTRY)<br><b>Md.</b>   |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>   |   | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>        |   | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore City</b> MD.         |   |  |  |
| 10. CITY OR TOWN OF DEATH<br><b>Balto.</b>   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Balto. City Hospital</b> |   |  |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)          |   | 12b. KIND OF BUSINESS OR INDUSTRY  |  |
| 13a. STATE<br><b>Md.</b>   |  |  | 13b. COUNTY<br><b>Balto.</b>  |  | 13c. CITY OR TOWN<br><b>Balto.</b>                                      |   | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Walter Rideout</b>  |  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Nellie Redman</b> |  |   | 13e. STREET ADDRESS<br><b>21237</b><br><b>2000 Odel Ave. Apt. 1321</b>    |   |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>No</b>  |  |  | 16b. SOCIAL SECURITY NO.<br><b>217-20-2276A</b>                       |  | 17. INFORMANT<br>ADDRESS<br><b>Elaine C. Jones 808 N. Montford Ave.</b> |   |   |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Cardio respiratory arrest</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <b>Massive cerebral infarction</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. |  |  |   |  |   |   |   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH   |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)  |  |  |   |  |   |   |   |  |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |   |  |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |   | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>19</b>   |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)   |   |   |   |  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE  |   |   |   |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>12-26</b> , 19 <b>84</b> , to <b>1-1</b> , 19 <b>85</b> , that (I) (we) lost saw the deceased alive on <b>1-1</b> , 19 <b>85</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.                              |  |  |   |  |   |   |   |  |  |
| 22b. SIGNATURE<br><b>M.W. Hawke</b>  |  |  |   | DEGREE<br><b>MP.</b><br>ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> |   |   |   | 22c. DATE SIGNED<br><b>1/1/85</b>  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>M.W. Hawke</b>   |  |  |   | 22e. ADDRESS   |   |   |   |  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>Burial</b>  |  | 23b. DATE<br><b>1-5-85</b>   |   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>New Cathedral</b>   |   | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Balto. City</b>          |   |  |  |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>Wm. C. March F/H 1101 E. North Ave.</b>   |  |  |   | ADDRESS  |   | 25. DATE REC'D. BY REGISTRAR<br><b>JAN 3 1985</b>                         |   | 25b. REGISTRAR'S SIGNATURE<br><b>Wardson-Randall</b>   |  |

MEDICAL CERTIFICATION

2000

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 5 0 1 5 6 1

1- FOR  
STATE  
REGISTRAR

REG. NO.

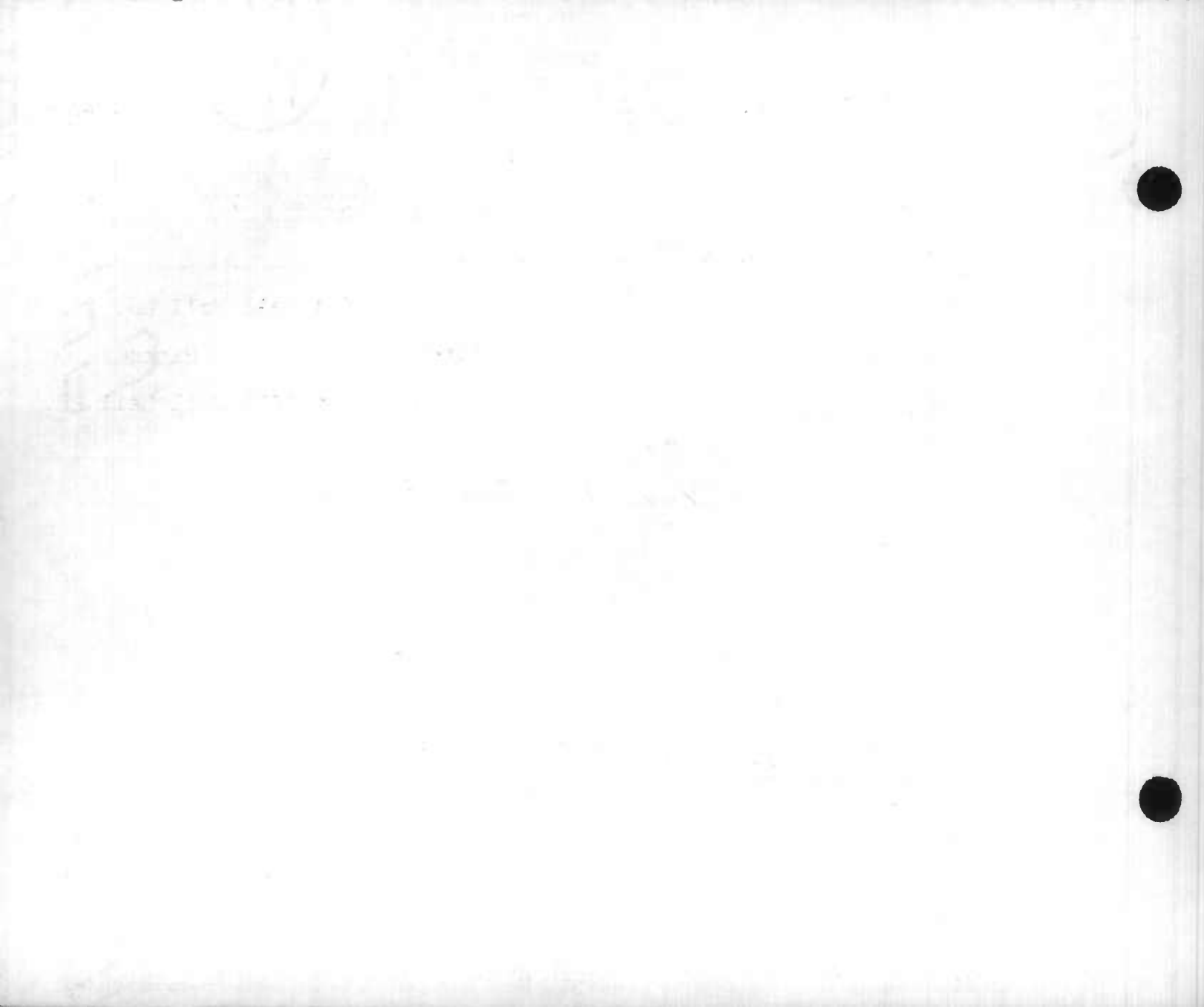
|  |   |   |   |  |  |
|--|---|---|---|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>WILLIE L. SMITH</b>   |   |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>1 10 85</b>   |  | 2b. HOUR<br><b>5:50AM</b> M  |
| 3 SEX<br><b>Male</b>   | 4 RACE<br><b>Black</b>  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>8 23 26</b>  |   | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>58</b> YRS.                              | IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS<br>HOURS MIN.  |
| 7a. BIRTHPLACE<br>(STATE OR FOREIGN COUNTRY)<br><b>S.C.</b>  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>BALTIMORE, CITY</b> MD.             |  |
| 10. CITY OR TOWN OF DEATH<br><b>Baltimore</b>  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>VAMC, BALTIMORE, MARYLAND 21218</b> |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)                                |  | 12b. KIND OF BUSINESS OR INDUSTRY  |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)  |   |   |   |  |  |
| 13a. STATE<br><b>MD</b>  | 13b. COUNTY   | 13c. CITY OR TOWN<br><b>Baltimore</b>   | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | 13e. STREET ADDRESS / ZIP CODE<br><b>4421 Pall Mall Rd. 21215</b>              |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Samuel Smith</b>  |   |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Florence Hines</b>                          |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)<br><b>Yes</b>   |   | 16b. SOCIAL SECURITY NO.<br><b>242-30-6513</b>  |   | 17. INFORMANT<br>ADDRESS<br><b>Elizabeth Duncan 4421 Pall Mall Rd.</b>         |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Cerebrovascular Accident</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <b>Chronic End Stage Renal Failure</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.  |   |   |   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH   |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: _____  |   |   |   |  |  |
| 19a. DATE OF OPERATION   |   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>      | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |   | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK   |   | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                              |  |
| 22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <b>12/27</b> , 19 <b>84</b> , to <b>1/10</b> , 19 <b>85</b> , that <input checked="" type="checkbox"/> (we) lost saw the deceased alive on <b>1/10</b> , 19 <b>85</b> , and that in <input checked="" type="checkbox"/> (our) opinion death occurred on the date and hour and from the causes stated above. <input checked="" type="checkbox"/> (we) did not view the body after death. |   |   |   |  |  |
| 22b. SIGNATURE<br>DEGREE<br><b>Lynn Ludmer MD</b><br>PHYSICIAN'S NAME (TYPE OR PRINT)  |   | 22c. DATE SIGNED<br><b>1/14/85</b>  |   | 22d. ADDRESS<br><b>3900 LOCH RAVEN BLVD. BALTIMORE, MARYLAND</b>               |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>Burial</b>  |   | 23b. DATE<br><b>1/14/85</b>   |   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Garrison Forest VA</b>                |  |
| 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Owings Mills MD</b>   |   | 24. FUNERAL DIRECTOR<br>NAME ADDRESS<br><b>Wm. C. March F/H 1101 E. North Ave.</b>  |   |  |  |
| 25a. DATE REC'D. BY REGISTRAR<br><b>JAN 11 1985</b>  |   | 25b. REGISTRAR'S SIGNATURE<br><b>William W. Handell</b>   |   |  |  |

BP \_\_\_\_\_

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.



STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8-5 01562

FOR  
STATE  
REGISTRAR

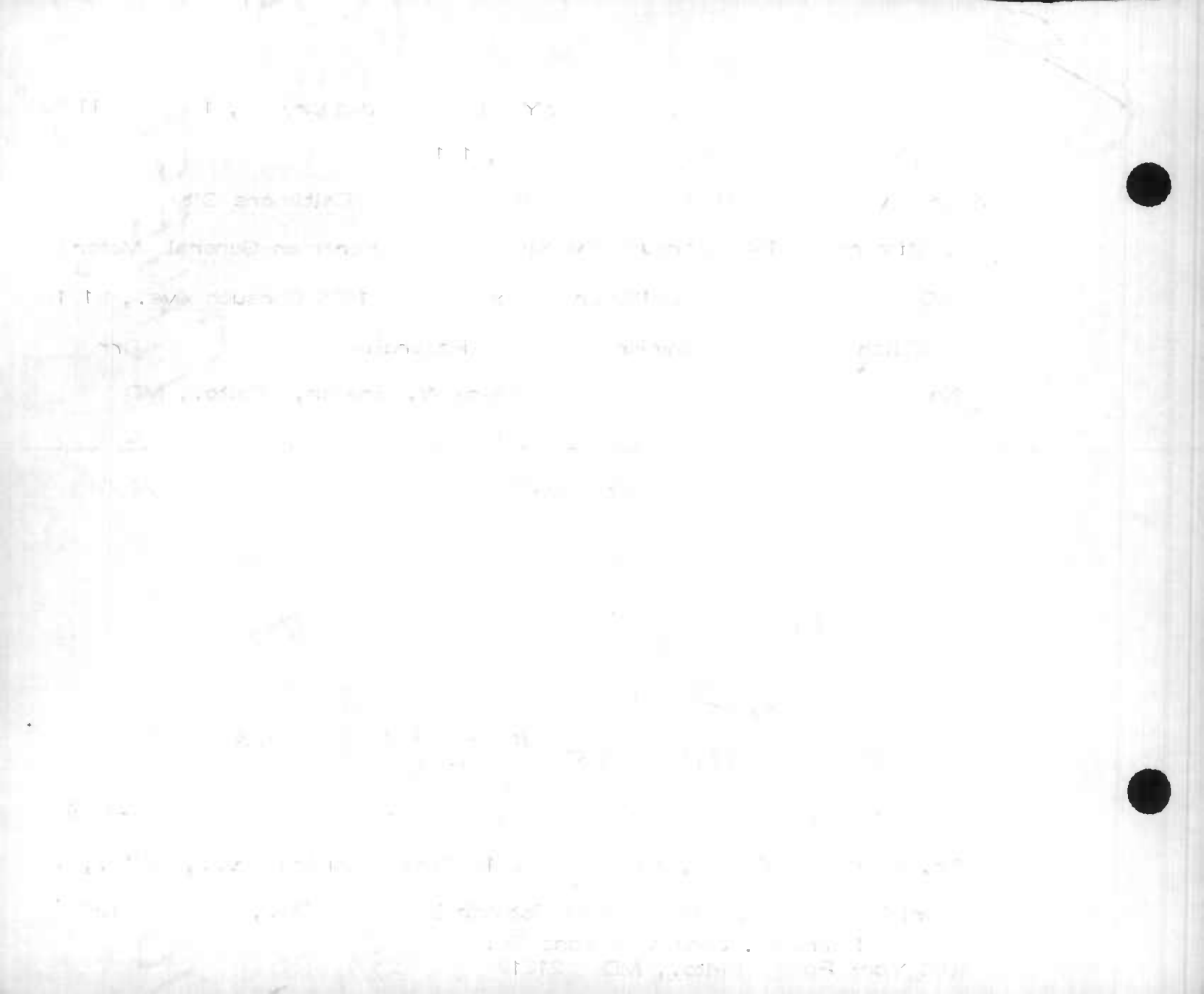
REG. NO.

|   |  |   |  |   |  |
|---|--|---|--|---|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>CARL D. SNYDER   |  |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br>January 30, 1985                                    |   | 2b. HOUR<br>11:30 AM   |
| 3. SEX<br>Male  | 4. RACE<br>White   | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>May 22, 1915  | 6. AGE (IN YEARS LAST BIRTHDAY)<br>69 YRS.   |   | IF UNDER 1 YEAR<br>MONTHS DAYS HOURS MIN.  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>West VA  | 7b. CITIZEN OF WHAT COUNTRY?<br>USA  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Baltimore City MD.                                 |   |  |
| 10. CITY OR TOWN OF DEATH<br>Baltimore  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>1435 Gorsuch Avenue |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Foreman-General Motors |   | 12b. KIND OF BUSINESS OR INDUSTRY  |
| 13a. STATE<br>MD  |  | 13b. COUNTY   | 13c. CITY OR TOWN<br>Baltimore   | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | 13e. STREET ADDRESS / ZIP CODE<br>1435 Gorsuch Ave., 21218                       |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>Elijah Snyder   |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Rosarella Orr  |  |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)<br>No  |  | 16b. SOCIAL SECURITY NO.  |  | 17. INFORMANT ADDRESS<br>Wayne W. Snyder, Balto., MD  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>cerebrovascular accident</u><br>DUE TO, OR AS A CONSEQUENCE OF (b) <u>ASLVD</u><br>DUE TO, OR AS A CONSEQUENCE OF (c)<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last |  |   |  |   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><u>10 hours</u><br><u>15 min</u> |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 11a  |  |   |  |   |  |
| 19a. DATE OF OPERATION<br><u>none</u>   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>            |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)                  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>   |  | 21e. PLACE OF INJURY<br>(STREET, FACTORY, OFFICE, FARM, ETC.)<br><u>none</u>  |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE<br><u>10/12 84</u> <u>1/30 85</u>             |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>1/22</u> 19 <u>85</u> , to <u>1/30</u> 19 <u>85</u> , that (I) (we) last saw the deceased alive on <u>1/22</u> 19 <u>85</u> , and that in my (our) opinion death occurred on the date and hour and from the causes stated above (I) (we) (did) (did not) view the body after death. |  |   |  |   |  |
| 22b. SIGNATURE<br><u>R Maurice Feldman MD</u>   |  | DEGREE<br>ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>        |  | 22c. DATE SIGNED<br><u>1/31/85</u>  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>Dr. Maurice Feldman, MD  |  | 22e. ADDRESS<br>6610 Cross Country Blvd., Balto., MD  |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br>Burial  | 23b. DATE<br>2/2/85  | 23c. NAME OF CEMETERY OR CREMATORY<br>New Cathedral   |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Balto., MD  |  |
| 24. FUNERAL DIRECTOR<br>NAME Henry W. Jenkins & Sons Co.<br>4905 York Road Balto., MD 21212   |  |   | 25a. DATE REC'D. BY REGISTRAR<br>FEB 4 1985  |   | 25b. REGISTRAR'S SIGNATURE<br><u>Julia Davidson-Randall</u>                      |

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 2 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

BP





REG. NO.

24. FUNERAL DIRECTOR  
Hebrew Memorial F.H.Inc. 100 Reisterstown Rd.  
Balt. MD 21208

25a. DATE REC'D. BY REGISTRAR  
JAN 29 1985

25b. REGISTRAR'S SIGNATURE  
Jeha Davidson-Randall

**TO MEDICAL EXAMINER:** THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE ADVISE THE MEDICAL EXAMINER BY TELEPHONE. THE MEDICAL EXAMINER MAY REQUEST THAT THE BODY BE OPENED FOR AUTOPSY. IF SO, PLEASE INDICATE IN ITEM 18, GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PA-3. RETAIN PAGE 5 FOR YOUR FILES.

**TO FUNERAL DIRECTOR:** PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 WASHINGTON STREET, BALTIMORE, MARYLAND 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

DHMH - 17  
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20% COTTON LIGER

EDWARD

WILLIAM

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STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 5 0 1 5 6 4

FOR  
1 - STATE  
REGISTRAR

REG. NO.

|   |  |   |  |   |   |   |   |   |   |  |
|---|--|---|--|---|---|---|---|---|---|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br><b>EMMA SODEN</b>  |  |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>1 13 85</b>  |   |   | 2b. HOUR<br><b>7<sup>50</sup> A M</b>   |   |   |   |  |
| 3 SEX<br><b>FEMALE</b>  |  | 4 RACE<br><b>BLACK</b>  |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>2 6 95</b>   |   | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>89</b> YRS.                                     |   | IF UNDER 1 YEAR<br>MONTHS DAYS HOURS MIN.<br><b>89</b>  |   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>BALTIMORE MD</b>  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore City MD.</b>                     |   |   |   |  |
| 10. CITY OR TOWN OF DEATH<br><b>Baltimore</b>   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>University of Maryland Hospital</b> |  |   |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Beautician</b> |   | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>Self-Employed</b>   |   |  |
| 13a. STATE<br><b>Maryland</b>   |  |   | 13b. COUNTY<br><b>—</b>  |   | 13c. CITY OR TOWN<br><b>Baltimore</b>   |   | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |   |   |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>William Cooper</b>   |  |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Emily Ridgeway</b>   |   |   | 16. STREET ADDRESS / ZIP CODE<br><b>807 HARLEM AVE / 21201</b>                        |   |   |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>No.</b>  |  |   | 16b. SOCIAL SECURITY NO.<br><b>213-48-3723</b>   |   | 17. INFORMANT<br><b>Elmer Soden</b>   |   |   |   | ADDRESS<br><b>807 Harlem Avenue<br/>Baltimore, Maryland 21201</b> |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>CARDIO - PULMONARY FAILURE</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <b>GRAM NEGATIVE SEPSIS</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <b>—</b>   |  |   |  |   |   |   |   |   | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH                   |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <b>—</b>   |  |   |  |   |   |   |   |   |   |  |
| 19a. DATE OF OPERATION<br><b>—</b>  |  |   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED<br><b>—</b>   |   |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |   | 20b. IF YES, WERE FINDINGS USED<br>IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |   |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  |   | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>  |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)             |   |   |   |   |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK  |  |   | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE<br><b>22 S. Greene St Balt MD 21201</b> |   |   |   |   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>Jan 2</b> , 19 <b>85</b> , to <b>Jan 13</b> , 19 <b>85</b> , that (I) (we) lost<br>saw the deceased alive on <b>Jan 13</b> , 19 <b>85</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated<br>above, (I) (we) (did) (did not) view the body after death. |  |   |  |   |   |   |   |   |   |  |
| 22b. SIGNATURE<br><b>Allen Solomon MD</b>   |  |   | DEGREE<br>ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> |   |   |   |   | 22c. DATE SIGNED<br><b>1/13/85</b>  |   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>Allen Solomon MD</b>  |  |   | 22e. ADDRESS<br><b>22 S. Greene St Balt MD 21201</b>   |   |   |   |   |   |   |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>Burial</b>   |  |   | 23b. DATE<br><b>1/18/1985</b>  |   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>King Memorial Park</b>                           |   | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Baltimore, Maryland</b>                        |   |   |  |
| 24. FUNERAL DIRECTOR<br>NAME ADDRESS<br><b>Nutter &amp; Sons 2501 Gwynns Funeral Home Inc.<br/>Funeral Home Inc. Baltimore, Maryland 21216</b>  |  |   |  |   | 25a. DATE REC'D. BY REGISTRAR<br><b>JAN 17 1985</b>                                       |   | 25b. REGISTRAR'S SIGNATURE<br><b>Fika Davidson-Randall</b>                                      |   |   |  |

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MEDICAL CERTIFICATION

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial/transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.



STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

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1. FOR  
STATE  
REGISTRAR

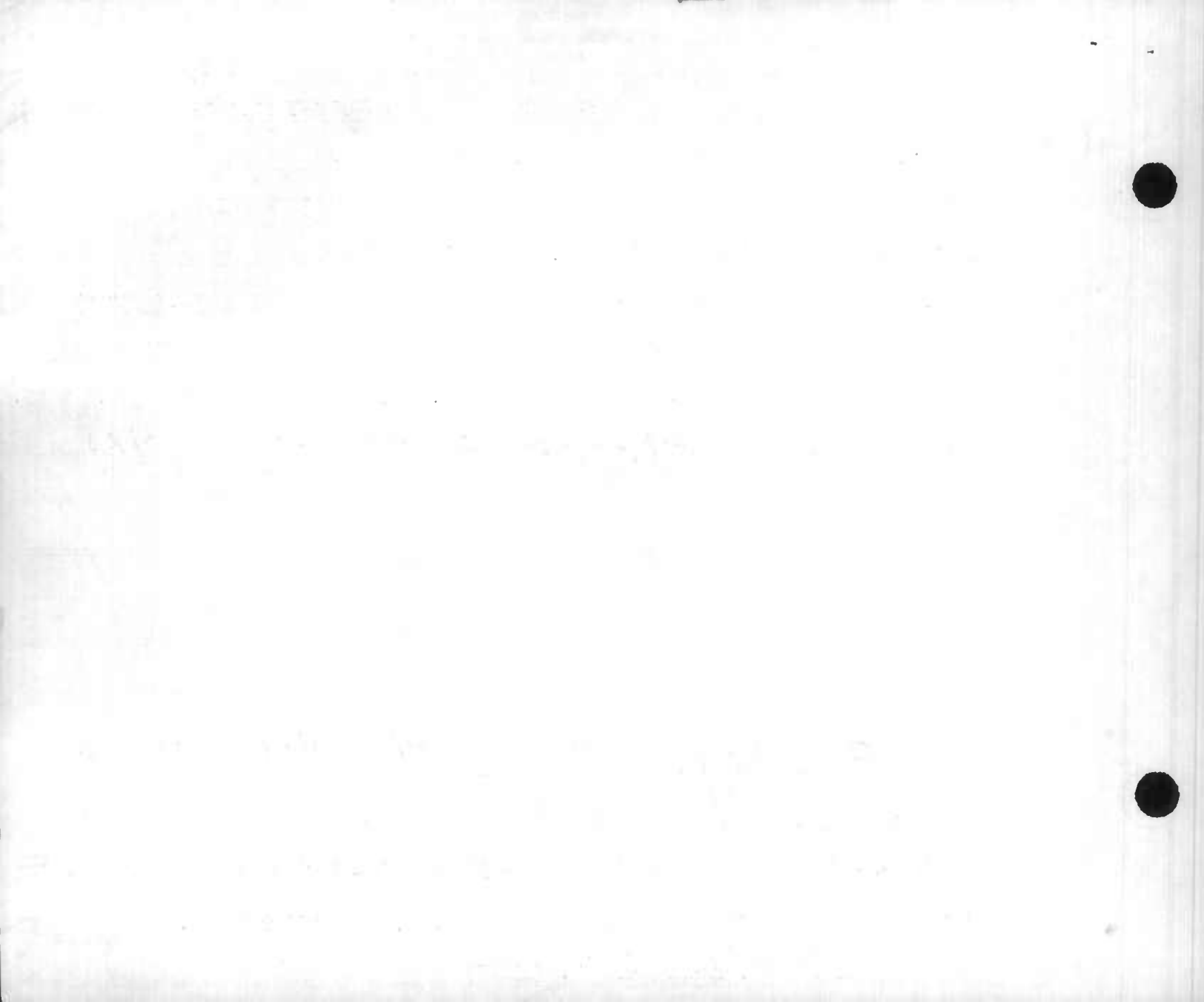
REG. NO.

|  |  |  |  |   |  |  |  |  |  |
|--|--|--|--|---|--|--|--|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br><b>IDA</b>  |  |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>JANUARY 27, 1985</b> |   |  | 2b. HOUR<br><b>7:00 AM</b>   |  |  |  |
| 3. SEX<br><b>FEMALE</b>  |  | 4. RACE<br><b>WHITE</b>  |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>SEPT. 12, 1923</b>   |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>61</b> YRS.                                    |  | 7. IF UNDER 1 YEAR<br>MONTHS DAYS HOURS MIN.   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>MARYLAND</b>   |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>   |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>BALTIMORE CITY</b> MD.                    |  |  |  |
| 10. CITY OR TOWN OF DEATH<br><b>BALTIMORE</b>  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>4253 LABYRINTH RD. (21215)</b> |  |   |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>HOUSEWIFE</b> |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>HOMEMAKER</b>  |  |
| 13a. STATE<br><b>MARYLAND</b>  |  | 13b. COUNTY<br><b>BALTIMORE</b>  |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>   |  | 13c. STREET ADDRESS / ZIP CODE<br><b>4253 LABYRINTH RD. (21215)</b>                  |  |  |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>SAMUEL COLLIDGE</b>   |  |  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>MOLLIE SCHAMUS</b>  |  |  |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>NO</b>  |  |  |  | 16b. SOCIAL SECURITY NO.<br><b>217-16-6574</b>  |  | 17. INFORMANT<br>ADDRESS<br><b>JERRY I. SOLOMON 4253 LABYRINTH RD. (21215)</b>       |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>CALUNG E METS</b>  |  |  |  |   |  |  |  | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH<br><b>YRS</b>  |  |
| DUE TO, OR AS A CONSEQUENCE OF   |  |  |  |   |  |  |  |  |  |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.   |  |  |  |   |  |  |  |  |  |
| DUE TO, OR AS A CONSEQUENCE OF   |  |  |  |   |  |  |  |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: 11a   |  |  |  |   |  |  |  |  |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  |   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)  |  |  |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |  |  |  |  |
| 22a. I certify that (1) (this hospital) attended the deceased from <b>Dec 19 84</b> to <b>1/27 85</b> , that (we) last saw the deceased alive on <b>1/19/85</b> , and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (If (we) (did) (did not) view the body after death. |  |  |  |   |  |  |  |  |  |
| 22b. SIGNATURE<br><b>Kenneth M. Jones MD</b>   |  |  |  |   |  |  |  | 22c. DATE SIGNED<br><b>1/28/85</b>   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>KENNETH JONES</b>  |  |  |  | 22e. ADDRESS<br><b>10807 FALLS RD LUTHERVILLE</b>   |  |  |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>BURIAL</b>  |  | 23b. DATE<br><b>1/28/85</b>  |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>WORKMENS CIRCLE CEM.</b>   |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>BALTIMORE, MD</b>                   |  |  |  |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>SOL LEVINSON &amp; BROS.</b>  |  |  |  | 25a. DATE REC'D BY REGISTRAR<br><b>JAN 29 1985</b>  |  | 25b. REGISTRAR'S SIGNATURE<br><b>[Signature]</b>                                     |  |  |  |
| 6010 REISTERSTOWN RD. BALTIMORE, MD. (21215)   |  |  |  |   |  |  |  |  |  |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon copies. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of one.



STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8501566

FOR  
1 - STATE  
REGISTRAR

REG. NO.

|   |  |  |  |   |  |   |  |  |   |   |  |   |  |  |
|---|--|--|--|---|--|---|--|--|---|---|--|---|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br><b>JOSEPH</b>  |  |  | MIDDLE<br><b>SORRENTINO</b>  |   |  | LAST<br><b>SORRENTINO</b>   |  |  | 2a. DATE OF DEATH MONTH DAY YEAR<br><b>JANUARY 6, 1985</b>                        |   |  | 2b. HOUR P M<br><b>7:26 P M</b>   |  |  |
| 3. SEX<br><b>Male</b>   |  |  | 4. RACE<br><b>Caucasian</b>  |   |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>April 2, 1915</b>  |  |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>69</b>                                      |   |  | 7. UNDER 1 YEAR<br>MONTHS DAYS<br><b>YRS</b>  |  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Maryland</b>  |  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>  |   |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>BALTIMORE CITY</b> MD.                 |   |  |   |  |  |
| 10. CITY OR TOWN OF DEATH<br><b>BALTIMORE</b>   |  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>THE JOHNS HOPKINS HOSPITAL</b> |   |  |   |  |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Plater</b> |   |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>Balto. City</b>   |  |  |
| 13a. STATE<br><b>Maryland</b>   |  |  |  |   |  | 13b. COUNTY<br><b>Baltimore</b>   |  |  | 13c. CITY OR TOWN<br><b>Baltimore</b>   |   |  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |  |
| 13e. STREET ADDRESS / ZIP CODE<br><b>935 Fordwood Circle</b>  |  |  |  |   |  | 13f. ZIP CODE<br><b>21228</b>   |  |  |   |   |  |   |  |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Gitano Sorrentino</b>  |  |  |  |   |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Rose (nee Torchi)</b>   |  |  |   |   |  |   |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>Yes</b>  |  |  | 16b. SOCIAL SECURITY NO.<br><b>WW11</b>  |   |  | 17. INFORMANT<br><b>Mrs. Millie Sorrentino</b>  |  |  | ADDRESS<br><b>935 Fordwood Cir. Baltimore, MD. 21228</b>                          |   |  |   |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Ventricular Tachycardia</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <b>Myocardial Infarction</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <b></b>  |  |  |  |   |  |   |  |  |   |   |  | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH<br><b>2 minute</b><br><b>11 days</b>            |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 11a   |  |  |  |   |  |   |  |  |   |   |  |   |  |  |
| 19a. DATE OF OPERATION  |  |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                          |  |   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |   | 20b. IF YES, WERE FINDINGS USED<br>IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |   |  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  |  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>12:27 P.M. 1985</b> |  |   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18. PART 1 OR PART 2)       |   |   |  |   |  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>  |  |  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)    |  |   |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                    |   |   |  |   |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>12/27</b> , 19 <b>84</b> , to <b>1/6</b> , 19 <b>85</b> , that (I) (we) lost<br>saw the deceased alive on <b>1/6</b> , 19 <b>85</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated<br>above, (I) (we) (did) (did not) view the body after death. |  |  |  |   |  |   |  |  |   |   |  |   |  |  |
| 22b. SIGNATURE<br><b>Henry Paul Parteman</b>  |  |  |  | DEGREE<br><b>PHYSICIAN</b>  |  |   |  | 22c. ADDRESS<br><b>601 N. WOLFE ST. BALTO. MD.</b>                                   |   |   |  | 22d. DATE SIGNED<br><b>1/6/85</b>   |  |  |
| 22e. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>PARTEMAN</b>  |  |  |  | 22f. ADDRESS<br><b>JOHNS HOPKINS HOSPITAL</b>                             |  |   |  |  |   |   |  |   |  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>Burial</b>   |  |  |  | 23b. DATE<br><b>Jan. 10/85</b>  |  |   |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Lake View Memorial</b>                      |   |   |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Sykesville Carroll MD.</b>                     |  |  |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>Loring Byers Funeral Directors, Inc.</b>   |  |  |  |   |  |   |  | 25a. DATE REC'D. BY REGISTRAR<br><b>JAN 10 1985</b>                                  |   | 25b. REGISTRAR'S SIGNATURE<br><b>[Signature]</b>  |  |   |  |  |
| 26. ADDRESS<br><b>8728 Liberty Rd. Randallstown, Maryland 21133</b>   |  |  |  |   |  |   |  |  |   |   |  |   |  |  |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death and retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Burial-transit permits are removed from carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of this.





Film G 603 item 6

1- FOR  
STATE 5/17/85 rja  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 5 0 1 5 6 7

REG. NO.

|  |  |   |   |   |  |
|--|--|---|---|---|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>ALBERT SPEARS</b>   |  |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR <b>1-6-85</b>   |   | 2b. HOUR<br><b>12 M</b>  |
| 3. SEX<br><b>M</b>   | 4. RACE<br><b>NEGRO</b>  | 5. DATE OF BIRTH<br>MONTH DAY YEAR <b>12 25 1900</b>  |   | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>84 80</b> YRS.                      |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>MD</b>   | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A</b>   | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>BALTO. CITY MD.</b>            |  |
| 10. CITY OR TOWN OF DEATH<br><b>BALTO.</b>   | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>506 LONDON AVE</b> |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>LABORER</b>              |   | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>Balto. Gas &amp; Elec.</b> |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)  |  |   |   |   |  |
| 13a. STATE<br><b>MD</b>  | 13b. COUNTY  | 13c. CITY OR TOWN<br><b>BALTO</b>   | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | 13e. STREET ADDRESS<br><b>506 LONDON AVE</b>                              |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>SPEARS</b>  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>BESSIE STANCIL</b>  |   |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR US UNKNOWN)<br><b>NO</b>   |  | 16b. SOCIAL SECURITY NO.<br><b>212 05-3464</b>  |   | 17. INFORMANT<br>NAME ADDRESS<br><b>James E. Powell 4709 Charlton Ave</b> |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>METASTATIC CARCINOMA</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <b>CARCINOMA OF ESOPHAGUS</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. |  |   |   |   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH                       |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) _____  |  |   |   |   |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>   |  | 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)    |   |   |  |
| 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |   |   |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                         |  |
| 22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.  |  |   |   |   |  |
| 22b. SIGNATURE<br><b>Baskaran MD</b>   |  |   |   | 22c. DATE SIGNED<br><b>1-8-85</b>   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>SAMBANDAM BASKARAN</b>   |  |   |   | 22e. ADDRESS<br><b>3455 Wilkens Ave Baltimore MD 21229</b>                |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>Burial</b>  |  | 23b. DATE<br><b>1/10/85</b>   |   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Anteburial men PK</b>            |  |
| 23d. LOCATION<br>(CITY OR TOWN) COUNTY STATE<br><b>B. &amp; O. County, Md</b>  |  | 24. FUNERAL DIRECTOR<br>NAME ADDRESS<br><b>Locks Funeral Home 1304 N. Central Ave</b>   |   |   |  |
| 25a. DATE REC'D. BY REGISTRAR<br><b>JAN 9 1985</b>   |  |   |   | 25b. REGISTRAR'S SIGNATURE<br><b>[Signature]</b>                          |  |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 1 and 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH  |   |   |  |   | REG. NO.  |  |
|---|---|---|--|---|---|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>William H. Spence  |   |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br>Jan. 4, 1985                                      |   | 2b. HOUR<br>21:39 M   |  |
| 3. SEX<br>Male  | 4. RACE<br>White  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>10 06 1906  |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br>78 YRS   | IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS<br>HOURS MIN. |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Baltimore  | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.A.  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Baltimore MD.   |   |  |
| 10. CITY OR TOWN OF DEATH<br>Baltimore  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>University of Md. Hospital |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Retired Paper Hanger |   | 12b. KIND OF BUSINESS OR INDUSTRY                               |  |
| 13a. STATE<br>Baltimore   |   | 13b. COUNTY<br>Baltimore  | 13c. CITY OR TOWN<br>Baltimore   | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |   |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>William Spence  |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Susan Corbit   |  | 13e. STREET ADDRESS / ZIP CODE<br>1 W. Conway St. Apt 203 21201                                 |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br>UNKNOWN   |   | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br>218-14-7491  |  | 17. INFORMANT ADDRESS   |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Cardiac Arrest</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <u>Ventricular Tachyarrhythmia</u><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last<br>(c) <u>Cardiomegaly and S/P MI</u><br>DUE TO, OR AS A CONSEQUENCE OF |   |   |  |   |   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH   |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:  |   |   |  |   |   |  |
| 19a. DATE OF OPERATION  |   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  | 20a. AUTOPSY?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>            |   | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |   | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)                  |   |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK  |   | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>12/17</u> 19 <u>84</u> , to <u>1/4</u> 19 <u>85</u> , that (I) (we) lost saw the deceased alive on <u>1/4</u> 19 <u>85</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.   |   |   |  |   |   |  |
| 22b. SIGNATURE<br><u>L. W. Lin MD</u>   |   | DEGREE<br>ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>        |  |   |   | 22c. DATE SIGNED<br><u>1/4/85</u>  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><u>Lin</u>   |   | 22e. ADDRESS<br><u>22. S. Green St</u>  |  |   |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><u>Cremation</u>   |   | 23b. DATE<br><u>Jan 7'85</u>  |  | 23c. NAME OF CEMETERY OR CREMATORY<br><u>Westview Memorial Pk</u>                               |   | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><u>Catonsville Balto., Md.</u>   |
| 24. FUNERAL DIRECTOR<br>NAME ADDRESS<br><u>Harry H Witzke 4112 Columbia RD Ellicott city</u>  |   |   |  | 25a. DATE REC'D. BY REGISTRAR<br><u>JAN 8 1985</u>  |   |  |
| 25b. REGISTRAR'S SIGNATURE<br><u>John Davidson-Randall</u>  |   |   |  |   |   |  |

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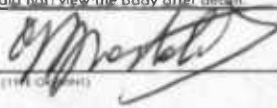
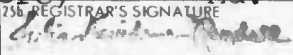
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

FOR  
1- STATE  
REGISTRAR

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

85 01569

REG. NO.

|  |  |  |   |   |  |  |   |   |   |  |
|--|--|--|---|---|--|--|---|---|---|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>Elder <b>THURMAN</b> <b>SPRUELL</b>   |  |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>01-17-85</b>                          |   |  | 2b. HOUR<br><b>10:00</b> M   |   |   |   |  |
| 3. SEX<br><b>Male</b>  |  | 4. RACE<br><b>Black</b>  |   | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>2 20 20</b>  |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>64</b> YRS.  |   | 7. IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS.<br>HOURS MIN.   |   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>N. Carolina</b>  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>  |   | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>BALTIMORE CITY</b> MD.  |   |   |   |  |
| 10. CITY OR TOWN OF DEATH<br><b>BALTIMORE</b>  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Bon Secours Hospital</b> |   |   |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)   |   | 12b. KIND OF BUSINESS OR INDUSTRY   |   |  |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE<br><b>Maryland</b>  |  |  |   |   | 13b. COUNTY<br><b>Baltimore</b>  |  | 13c. CITY OR TOWN<br><b>Baltimore</b>   |   | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Arthur Griffin</b>  |  |  |   |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Mattie Spruell</b>         |  |   |   |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>NO</b>  |  |  | 16b. SOCIAL SECURITY NO.<br><b>213-28-1142</b>                                  |   | 17. INFORMANT<br>ADDRESS<br><b>Delia A. Spurell 19 N. Carrollton Ave</b>       |  |   |   |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Terminal Ca -</b><br>DUE TO, OR AS A CONSEQUENCE OF (b) <b>Metastatic Ca of pancreas</b><br>DUE TO, OR AS A CONSEQUENCE OF (c) _____   |  |  |   |   |  |  |   | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH   |   |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 11a:   |  |  |   |   |  |  |   |   |   |  |
| 19a. DATE OF OPERATION<br><b>1/8/85</b>  |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED<br><b>obstructive jaundice</b> |   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |   | 20b. IF YES, WERE FINDINGS USED<br>IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |   |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>               |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) |  |   |   |   |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>   |  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)          |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                              |  |   |   |   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>1/17</b> , 19 <b>85</b> , to <b>1/17</b> , 19 <b>85</b> , that (I) (we) last saw the deceased alive on <b>1/17</b> , 19 <b>85</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |  |  |   |   |  |  |   |   |   |  |
| 22b. SIGNATURE<br>  |  |  | DEGREE  |   |  | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> |   | 22c. DATE SIGNED<br><b>1/17/85</b>  |   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)  |  |  | 22e. ADDRESS  |   |  |  |   |   |   |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>BURIAL</b>  |  |  | 23b. DATE<br><b>1/22/85</b>   |   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Mount Auburn Cem.</b>                 |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Baltimore Md.</b>  |   |   |  |
| 24. FUNERAL DIRECTOR<br>NAME ADDRESS<br><b>Wm C March F/H Inc. 1101 E North Avenue</b>   |  |  |   |   | 25a. DATE REC'D. BY REGISTRAR  |  | 25b. REGISTRAR'S SIGNATURE<br> |   |   |  |

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STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 5 0 1 5 7 0

FOR  
1 - STATE  
REGISTRAR

REG. NO.

|   |  |   |   |  |                                   |
|---|--|---|---|--|-----------------------------------|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>FIRST MIDDLE LAST<br>Marcella Q Stanley  |  |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br>1 2 85                     |  | 2b. HOUR<br>8:40 A.M.             |
| 3. SEX<br>Female  | 4. RACE<br>Black   | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>1 28 25   |   | 6. AGE (IN YEARS LAST BIRTHDAY)<br>59 YRS.                 |                                   |
| 7a. BIRTHPLACE<br>(STATE OR FOREIGN COUNTRY)                                    | 7b. CITIZEN OF WHAT COUNTRY?<br>United States  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> |   | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Baltimore City MD. |                                   |
| 10. CITY OR TOWN OF DEATH<br>Baltimore  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>University of Maryland Hospital |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)  |  | 12b. KIND OF BUSINESS OR INDUSTRY |
| 13a. STATE<br>Maryland  |  |   | 13b. COUNTY   | 13c. CITY OR TOWN<br>Baltimore                             |                                   |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>Samuel - Quinney                      |  |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Perry - Johnston |  |                                   |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br>Unknown |  | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br>214-36-9436  |   | 17. INFORMANT<br>Chart                                     |                                   |

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)  
PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a)

Cardiopulmonary arrest

DUE TO, OR AS A CONSEQUENCE OF

Conditions, if any, which  
gave rise to immediate  
cause (a), stating the  
underlying cause last.

(b) Metastatic breast cancer

DUE TO, OR AS A CONSEQUENCE OF

(c)

APPROXIMATE INTERVAL  
BETWEEN ONSET AND DEATH

~45 minutes

1978

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a.

19a. DATE OF OPERATION

None

19b. CONDITION FOR WHICH OPERATION WAS PERFORMED

20a. AUTOPSY?

YES ☐ NO ☒20b. IF YES, WERE FINDINGS USED  
IN CERTIFYING CAUSES OF DEATH?YES ☐ NO ☐21a. ACCIDENT WAS UNDERLYING ☐  
OR CONTRIBUTING ☐ CAUSE OF DEATH  
(IF EITHER NOTIFY MEDICAL EXAMINER)21b. TIME OF INJURY  
HOUR A.M. MONTH DAY YEAR  
P.M. 19

21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18. PART I OR PART 2)

21d. INJURY OCCURRED

WHILE ☐ NOT WHILE ☐  
AT WORK AT WORK21e. PLACE OF INJURY  
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)

21f. LOCATION

STREET CITY OR TOWN COUNTY STATE

22a. I certify that (I) (this hospital) attended the deceased from 10-27, 1984, to 1-2, 1985, that (I) (we) last saw the deceased alive on 1-2, 1985, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) did (did not) view the body after death.

22b. SIGNATURE

S. Marshall MD

DEGREE

ATTENDING PHYSICIAN ☐ MEDICAL DIRECTOR ☐ STAFF PHYSICIAN ☒

22c. DATE SIGNED

1/2/85

22d. PHYSICIAN'S NAME (TYPE OR PRINT)

S. Marshall MD

22e. ADDRESS

University of Maryland Hospital 225 Greene St.

23a. BURIAL, CREMATION, REMOVAL  
(TYPE OR PRINT)

CREMATION

23b. DATE

1-4-85

23c. NAME OF CEMETERY OR CREMATORY

Westview Crematory

23d. LOCATION

Baltimore Co., Md.

24. FUNERAL DIRECTOR

NAME

James A. Moxton &amp; Son

ADDRESS

1701 LAURENS ST.

25a. DATE REC'D. BY REGISTRAR

JAN 4 1985

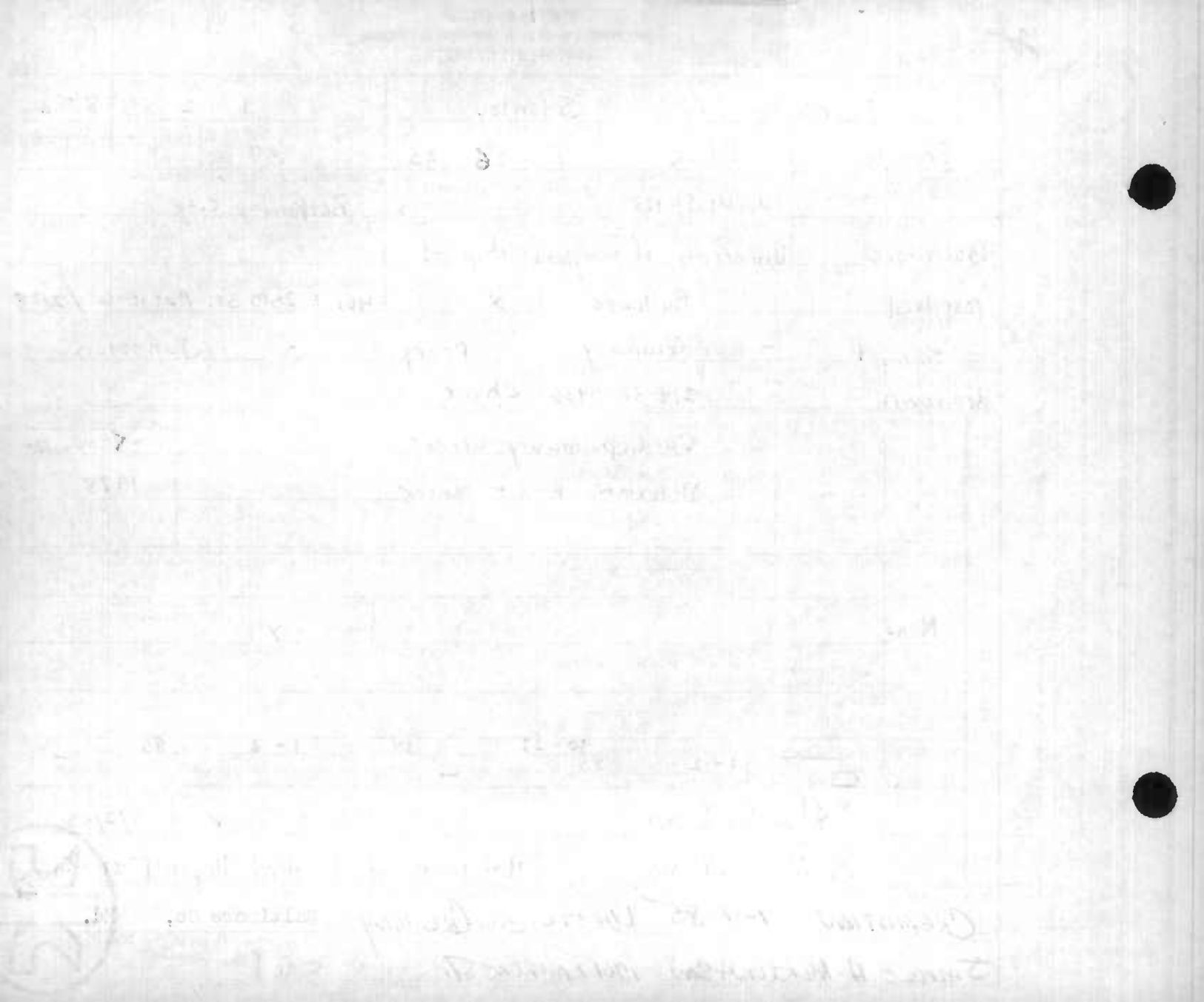
REGISTRAR'S SIGNATURE

John Davidson

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 4 should be detached for use as the burial-transit permit. Then please remove carbon copies. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use at the burial/interment permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8501571

FOR  
1 - STATE  
REGISTRAR

REG. NO.

|  |   |  |   |  |  |
|--|---|--|---|--|--|
| 1 DECEASED NAME<br>(TYPE OR PRINT)<br>JACOB (nmi) STANTON  |   |  | 2a DATE OF DEATH<br>MONTH DAY YEAR<br>1 19 85   |  | 2b HOUR<br>11:55p M                          |
| 3 SEX<br>MALE  | 4 RACE<br>WHITE   | 5 DATE OF BIRTH<br>MONTH DAY YEAR<br>5 10 1911   | 6 AGE (IN YEARS LAST BIRTHDAY)<br>73 YRS.   | 7 IF UNDER 1 YEAR<br>MONTHS DAYS<br>8 IF UNDER 24 HRS.<br>HOURS MIN.   |  |
| 7a BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>PENNSYLVANNIA  | 7b CITIZEN OF WHAT COUNTRY?<br>U.S.A.   | 8 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 9 BALTIMORE CITY OR COUNTY OF DEATH<br>BALTIMORE CITY, MD.                            |  |  |
| 10 CITY OR TOWN OF DEATH<br>BALTIMORE  | 11 NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>VAMC 3900 LOCH RAVEN BLVD 21218 |  | 12a USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>SPECIALIST 2nd CL. | 12b KIND OF BUSINESS OR INDUSTRY<br>U.S. ARMY  |  |
| 13a STATE<br>MARYLAND  |   | 13b COUNTY<br>21224  | 13c CITY OR TOWN<br>BALTIMORE   | 13d INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                                       |  |
| 14 FATHER'S NAME<br>FIRST MIDDLE LAST<br>ALEXANDER STANTON   |   | 15 MOTHER'S MAIDEN NAME<br>FIRST MIDDLE<br>ANNE WELZA  |   |  |  |
| 16a WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br>YES   | 16b SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br>WW II   | 17 INFORMANT<br>ADDRESS<br>ALEXANDER STANTON 6819 BESSEMER AVE. 21222<br>VAMC 3900 LOCH RAVEN BLVD 21218   |   |  |  |
| 18 CAUSE OF DEATH (Enter only one cause per line for PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) _____<br>DUE TO, OR AS A CONSEQUENCE OF (b) _____<br>DUE TO, OR AS A CONSEQUENCE OF (c) _____<br>CONDITIONS, if any, which gave rise to immediate cause (a), stating the underlying cause last<br>ANAPLASTIC SARCOMA INVOLVING LEFT LUNG<br>PULMONARY ARTERY AND CHEST WALL |   |  |   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)   |   |  |   |  |  |
| 19a DATE OF OPERATION  | 19b CONDITION FOR WHICH OPERATION WAS PERFORMED   |  | 20a AUTOPSY?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>   | 20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER NOTIFY MEDICAL EXAMINER)   | 21b TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19   | 21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)   |   |  |  |
| 21d INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK  | 21e PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   | 21f LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |   |  |  |
| 22a I certify that (X) (this hospital) attended the deceased from JANUARY 7, 19 85, to JANUARY 19, 19 85, that (X) (we) last saw the deceased alive on JANUARY 19, 19 85, and that in (X) (our) opinion death occurred on the date and hour and from the causes stated above, (Y) (we) did (did not) view the body after death.  |   |  |   |  |  |
| 22b SIGNATURE<br>Clare Bradley M.D.  |   | DEGREE<br>ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>       |   | 22c DATE SIGNED<br>1-22-85   |  |
| 22d PHYSICIAN'S NAME (TYPE OR PRINT)<br>Clare Bradley M.D.   |   | 22e ADDRESS<br>3900 LOCH RAVEN BLVD BALTO, MD 21218  |   |  |  |
| 23a BURIAL, CREMATION, REMOVAL (SPECIFY)<br>CREMATION  | 23b DATE<br>1/22/1985   | 23c NAME OF CEMETERY OR CREMATORY<br>GREEN MOUNT CEMETERY  | 23d LOCATION<br>CITY OR TOWN COUNTY STATE<br>BALTIMORE MD                             |  |  |
| 24 FUNERAL DIRECTOR<br>NAME<br>WALTER BROOKS BRADLEY, INC. BALTO., MD  |   |  | 25a DATE REC'D. BY REGISTRAR<br>25b REGISTRAR'S SIGNATURE<br>IAN 22 2 1985            |  |  |

BP

32

(100)

ST. LOUIS

ST. LOUIS

ST. LOUIS

A.S.W.

ATTORNEY

ST. LOUIS

ST. LOUIS

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ST. LOUIS

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ST. LOUIS

W. B. G. G. G.

ST. LOUIS

ST. LOUIS

ST. LOUIS

## REG. NO.

|  |  |               |  |  |  |  |  |   |  |  |  |  |  |  |  |   |  |                          |  |
|--|--|---------------|--|--|--|--|--|---|--|--|--|--|--|--|--|---|--|--------------------------|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT) JAMES J. STANTON JR.   |  |               |  |  |  | LAST FIRST MIDDLE                                    |  |   |  |  |  | 2a. DATE KNOWN OF DEATH ESTI-<br>MATED <input checked="" type="checkbox"/> MONTH DAY YEAR 1-25-85 19 |  |  |  |   |  | 2b. HOUR MINUTE 11:40 AM |  |
| 3. SEX Male  |  | 4. RACE Black |  | 5. DATE OF BIRTH MONTH DAY YEAR 5 5 1962                                   |  | 6. AGE IN YEARS LAST BIRTHDAY 22 YRS.                |  | 7. IF UNDER 1 YR. MONTHS DAYS   |  | IF UNDER 24 HRS. HOURS MIN.  |  | 2c. DATE PRONOUNCED DEAD 1-25-85 19  |  |  |  | 2d. PURCHASER'S NAME AND ADDRESS                                    |  |                          |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Maryland  |  |               |  | 7b. CITIZEN OF WHAT COUNTRY?<br>U. S. A.                                   |  |  |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  |  |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Baltimore City MD  |  |  |  |   |  |                          |  |
| 10. CITY OR TOWN OF DEATH<br>Baltimore   |  |               |  | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION<br>Sinai Hospital |  |  |  |   |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Laborer |  |  |  | 12b. KIND OF BUSINESS OR INDUSTRY<br>Crab House K                                |  |   |  |                          |  |
| USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)   |  |               |  |  |  |  |  |   |  |  |  |  |  |  |  |   |  |                          |  |
| 13a. STATE Maryland  |  |               |  | 13b. COUNTY  |  |  |  | 13c. CITY OR TOWN Baltimore   |  |  |  | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>         |  |  |  | 13e. STREET ADDRESS 4000 Groveland Avenue Baltimore, Maryland 21215 |  |                          |  |
| 14. FATHER'S NAME FIRST MIDDLE LAST James J. Stanton Sr.   |  |               |  |  |  | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Elsie Ray |  |   |  |  |  |  |  |  |  |   |  |                          |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) No.   |  |               |  | 16b. SOCIAL SECURITY NO. 214-72-9026                                       |  |  |  | 17. INFORMANT ADDRESS 4000 Groveland Ave. James J. Stanton Jr. Baltimore, Md. 21215   |  |  |  |  |  |  |  |   |  |                          |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1 DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) Fatty Liver<br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.<br>(b)<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c)   |  |               |  |  |  |  |  |   |  |  |  |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH                                     |  |   |  |                          |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)   |  |               |  |  |  |  |  |   |  |  |  |  |  |  |  |   |  |                          |  |
| 19a. DATE OF OPERATION   |  |               |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?                          |  |  |  |   |  |  |  |  |  | 20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |   |  |                          |  |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH  |  |               |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19                       |  |  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)   |  |  |  |  |  |  |  |   |  |                          |  |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>   |  |               |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)                |  |  |  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE  |  |  |  |  |  |  |  |   |  |                          |  |
| 22a. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> . |  |               |  |  |  |  |  |   |  |  |  |  |  |  |  |   |  |                          |  |
| ACTUAL SIGNATURE Margaret M. Korell  |  |               |  | TITLE (SPECIFY) M.D. Assistant MEDICAL EXAMINER                            |  |  |  | DATE SIGNED 1-26-85   |  |  |  |  |  |  |  |   |  |                          |  |
| EXAMINER'S NAME (TYPE OR PRINT) Margarita A. Korell, M.D.  |  |               |  | ADDRESS 111 Penn Street  |  |  |  |   |  |  |  |  |  |  |  |   |  |                          |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial   |  |               |  | 23b. DATE 1/31/1985  |  |  |  | 23c. NAME OF CEMETERY OR CREMATORY Md. National Mem. Park   |  |  |  | 23d. LOCATION CITY OR TOWN COUNTY STATE Laurel, Maryland   |  |  |  |   |  |                          |  |
| 24. FUNERAL DIRECTOR NAME AND ADDRESS Walter & Sons 2501 Gwynns Falls Parkway Funeral Home Inc. Baltimore, Maryland 21216  |  |               |  |  |  |  |  | 25a. DATE REC'D. BY REGISTRAR JAN 30 1985   |  |  |  | 25b. REGISTRAR'S SIGNATURE [Signature]   |  |  |  |   |  |                          |  |

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 1B. GIVE PAPERS 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PW 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL. TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED. WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

DHARH - 17  
(VR A15 ME (5))

• A • 2 • 3

Chris Holden

2007-2008

1997, 1998, 1999, 2000, 2001, 2002, 2003, 2004, 2005, 2006, 2007, 2008, 2009, 2010, 2011, 2012, 2013, 2014, 2015, 2016, 2017, 2018, 2019, 2020, 2021, 2022, 2023, 2024, 2025, 2026, 2027, 2028, 2029, 2030, 2031, 2032, 2033, 2034, 2035, 2036, 2037, 2038, 2039, 2040, 2041, 2042, 2043, 2044, 2045, 2046, 2047, 2048, 2049, 2050, 2051, 2052, 2053, 2054, 2055, 2056, 2057, 2058, 2059, 2060, 2061, 2062, 2063, 2064, 2065, 2066, 2067, 2068, 2069, 2070, 2071, 2072, 2073, 2074, 2075, 2076, 2077, 2078, 2079, 2080, 2081, 2082, 2083, 2084, 2085, 2086, 2087, 2088, 2089, 2090, 2091, 2092, 2093, 2094, 2095, 2096, 2097, 2098, 2099, 2100, 2101, 2102, 2103, 2104, 2105, 2106, 2107, 2108, 2109, 2110, 2111, 2112, 2113, 2114, 2115, 2116, 2117, 2118, 2119, 2120, 2121, 2122, 2123, 2124, 2125, 2126, 2127, 2128, 2129, 2130, 2131, 2132, 2133, 2134, 2135, 2136, 2137, 2138, 2139, 2140, 2141, 2142, 2143, 2144, 2145, 2146, 2147, 2148, 2149, 2150, 2151, 2152, 2153, 2154, 2155, 2156, 2157, 2158, 2159, 2160, 2161, 2162, 2163, 2164, 2165, 2166, 2167, 2168, 2169, 2170, 2171, 2172, 2173, 2174, 2175, 2176, 2177, 2178, 2179, 2180, 2181, 2182, 2183, 2184, 2185, 2186, 2187, 2188, 2189, 2190, 2191, 2192, 2193, 2194, 2195, 2196, 2197, 2198, 2199, 2200, 2201, 2202, 2203, 2204, 2205, 2206, 2207, 2208, 2209, 2210, 2211, 2212, 2213, 2214, 2215, 2216, 2217, 2218, 2219, 2220, 2221, 2222, 2223, 2224, 2225, 2226, 2227, 2228, 2229, 2230, 2231, 2232, 2233, 2234, 2235, 2236, 2237, 2238, 2239, 2240, 2241, 2242, 2243, 2244, 2245, 2246, 2247, 2248, 2249, 2250, 2251, 2252, 2253, 2254, 2255, 2256, 2257, 2258, 2259, 2260, 2261, 2262, 2263, 2264, 2265, 2266, 2267, 2268, 2269, 2270, 2271, 2272, 2273, 2274, 2275, 2276, 2277, 2278, 2279, 2280, 2281, 2282, 2283, 2284, 2285, 2286, 2287, 2288, 2289, 2290, 2291, 2292, 2293, 2294, 2295, 2296, 2297, 2298, 2299, 2300, 2301, 2302, 2303, 2304, 2305, 2306, 2307, 2308, 2309, 2310, 2311, 2312, 2313, 2314, 2315, 2316, 2317, 2318, 2319, 2320, 2321, 2322, 2323, 2324, 2325, 2326, 2327, 2328, 2329, 2330, 2331, 2332, 2333, 2334, 2335, 2336, 2337, 2338, 2339, 2340, 2341, 2342, 2343, 2344, 2345, 2346, 2347, 2348, 2349, 2350, 2351, 2352, 2353, 2354, 2355, 2356, 2357, 2358, 2359, 2360, 2361, 2362, 2363, 2364, 2365, 2366, 2367, 2368, 2369, 2370, 2371, 2372, 2373, 2374, 2375, 2376, 2377, 2378, 2379, 2380, 2381, 2382, 2383, 2384, 2385, 2386, 2387, 2388, 2389, 2390, 2391, 2392, 2393, 2394, 2395, 2396, 2397, 2398, 2399, 2400, 2401, 2402, 2403, 2404, 2405, 2406, 2407, 2408, 2409, 2410, 2411, 2412, 2413, 2414, 2415, 2416, 2417, 2418, 2419, 2420, 2421, 2422, 2423, 2424, 2425, 2426, 2427, 2428, 2429, 2430, 2431, 2432, 2433, 2434, 2435, 2436, 2437, 2438, 2439, 2440, 2441, 2442, 2443, 2444, 2445, 2446, 2447, 2448, 2449, 2450, 2451, 2452, 2453, 2454, 2455, 2456, 2457, 2458, 2459, 2460, 2461, 2462, 2463, 2464, 2465, 2466, 2467, 2468, 2469, 2470, 2471, 2472, 2473, 2474, 2475, 2476, 2477, 2478, 2479, 2480, 2481, 2482, 2483, 2484, 2485, 2486, 2487, 2488, 2489, 2490, 2491, 2492, 2493, 2494, 2495, 2496, 2497, 2498, 2499, 2500, 2501, 2502, 2503, 2504, 2505, 2506, 2507, 2508, 2509, 2510, 2511, 2512, 2513, 2514, 2515, 2516, 2517, 2518, 2519, 2520, 2521, 2522, 2523, 2524, 2525, 2526, 2527, 2528, 2529, 2530, 2531, 2532, 2533, 2534, 2535, 2536, 2537, 2538, 2539, 2540, 2541, 2542, 2543, 2544, 2545, 2546, 2547, 2548, 2549, 2550, 2551, 2552, 2553, 2554, 2555, 2556, 2557, 2558, 2559, 2560, 2561, 2562, 2563, 2564, 2565, 2566, 2567, 2568, 2569, 2570, 2571, 2572, 2573, 2574, 2575, 2576, 2577, 2578, 2579, 2580, 2581, 2582, 2583, 2584, 2585, 2586, 2587, 2588, 2589, 2590, 2591, 2592, 2593, 2594, 2595, 2596, 2597, 2598, 2599, 2600, 2601, 2602, 2603, 2604, 2605, 2606, 2607, 2608, 2609, 2610, 2611, 2612, 2613, 2614, 2615, 2616, 2617, 2618, 2619, 2620, 2621, 2622, 2623, 2624, 2625, 2626, 2627, 2628, 2629, 2630, 2631, 2632, 2633, 2634, 2635, 2636, 2637, 2638, 2639, 2640, 2641, 2642, 2643, 2644, 2645, 2646, 2647, 2648, 2649, 2650, 2651, 2652, 2653, 2654, 2655, 2656, 2657, 2658, 2659, 2660, 2661, 2662, 2663, 2664, 2665, 2666, 2667, 2668, 2669, 2670, 2671, 2672, 2673, 2674, 2675, 2676, 2677, 2678, 26

• 3.

- **Exhibit**

155 - 200 - 2000

General Home Sec. Baltimore, Maryland 21210  
 Robert L Davis 2301 Evans Hall Parkway  
 Towson, Md. 21204

1974



BP

DHMH - 16 50M 4/82  
(VRA 15, 4)

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, a medical examiner must be notified.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH   |  |  |  |  | REG. NO. 8501573   |   |   |                             |                                |
|--|--|--|--|--|--|---|---|-----------------------------|--------------------------------|
| 1. FOR STATE REGISTRAR   |  |  |  |  | 2a. DATE OF DEATH  |   |   |                             |                                |
| 1. DECEASED NAME (TYPE OR PRINT) <b>Ruth Statham</b>   |  |  |  |  | MONTH DAY YEAR 1 23 85   |   |   |                             | 2b. HOUR 12 <sup>44</sup> P.M. |
| 3. SEX <b>F</b>  | 4. RACE <b>B</b>                           | 5. DATE OF BIRTH MONTH DAY YEAR 1 03 31  |  | 6. AGE (IN YEARS LAST BIRTHDAY) 54 YRS.  |  | IF UNDER 1 YEAR MONTHS DAYS                                   |   | IF UNDER 24 HRS. HOURS MIN. |                                |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Jackson, Miss.</b>  | 7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b> |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH <b>City</b> MD.                                   |   |   |                             |                                |
| 10. CITY OR TOWN OF DEATH <b>Balto</b>   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Good Samaritan</b> |  |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Real Estate Agent</b> |   | 12b. KIND OF BUSINESS OR INDUSTRY <b>Real Estate</b>  |                             |                                |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE <b>Md.</b> 13b. CITY OR TOWN <b>Balto.</b> 13c. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>   |  |  |  |  | 13d. STREET ADDRESS <b>9810 Clanford - 21133</b>                                       |   |   |                             |                                |
| 14. FATHER'S NAME FIRST MIDDLE LAST <b>Calvin Herron</b>   |  |  | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Leona Berry Gaines</b>   |  |  |   |   |                             |                                |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>No</b>  |  | 16b. SOCIAL SECURITY NO. <b>428-48-5348</b>  |  | 17. INFORMANT ADDRESS <b>Michael Statham 9810 Clanford Rd.</b>   |  |   |   |                             |                                |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>respiratory failure</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last<br>(b) <b>cor pulmonate</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <b>progressive systemic sclerosis</b><br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>12<sup>44</sup> pm</b><br><b>Summer '84</b><br><b>X yrs.</b> |  |  |  |  |  |   |   |                             |                                |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <b>intense peripheral vasospasm</b>   |  |  |  |  |  |   |   |                             |                                |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  |  | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>                 |   | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> |                             |                                |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)  |  |   |   |                             |                                |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>   |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE   |  |   |   |                             |                                |
| 22a. I certify that (a) (this hospital) attended the deceased from <b>Jan. 3, 1985</b> to <b>Jan 23, 1985</b> , that (a) (we) lost saw the deceased alive on <b>Jan 3, 1985</b> , and that in (c) (my) (our) opinion death occurred on the date and hour and from the causes stated above (b) (we) (did) (did not) view the body after death.  |  |  |  |  |  |   |   |                             |                                |
| 22b. SIGNATURE <b>Scott C. Remick</b> DEGREE <b>M.D.</b>   |  |  |  | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> |  | 22c. DATE SIGNED <b>1/23/85</b>                               |   |                             |                                |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>SCOTT C. REMICK</b>   |  |  |  | 22e. ADDRESS   |  |   |   |                             |                                |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>  |  | 23b. DATE <b>1-26-85</b>   |  | 23c. NAME OF CEMETERY OR CREMATORY <b>Lakeview</b>   |  | 23d. LOCATION CITY OR TOWN COUNTY STATE <b>Baltimore, Md.</b> |   |                             |                                |
| 24. FUNERAL DIRECTOR NAME <b>James P. Mooton</b> ADDRESS <b>1701 Laurens St.</b>   |  |  |  | 25a. DATE REC'D. BY REGISTRAR <b>JAN 28 1985</b>   |  | 25b. REGISTRAR'S SIGNATURE <b>John Davidson-Randall</b>       |   |                             |                                |

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MEDICAL CERTIFICATION



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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

85 01574

1- FOR  
STATE  
REGISTRAR

REG. NO.

|  |   |  |   |  |  |
|--|---|--|---|--|--|
| 1 DECEASED NAME<br>(TYPE OR PRINT)<br>ALMA G. STARK  |   |  | 2a DATE OF DEATH<br>MONTH DAY YEAR<br>January 16, 1985  |  | 2b HOUR<br>11:25 AM  |
| 3 SEX<br>Female  | 4 RACE<br>White   | 5 DATE OF BIRTH<br>MONTH DAY YEAR<br>5 8 1899  |   | 6 AGE (IN YEARS LAST BIRTHDAY)<br>85 YRS.  | IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS.<br>HOURS MIN. |
| 7a BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Maryland   | 7b CITIZEN OF WHAT COUNTRY?<br>U.S.A.   | 8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 9 BALTIMORE CITY OR COUNTY OF DEATH<br>Baltimore City MD.   |  |  |
| 10 CITY OR TOWN OF DEATH<br>Baltimore  | 11 NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>Church Hospital Corporation |  | 12a USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Housewife  | 12b KIND OF BUSINESS OR INDUSTRY   |  |
| 13a USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a STATE 13b COUNTY<br>Maryland Baltimore  |   |  | 13c CITY OR TOWN<br>Edgemere  | 13d INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |
| 14 FATHER'S NAME<br>FIRST MIDDLE LAST<br>Gilbert Warnick   |   |  | 15 MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Gouldie Bernard   |  |  |
| 16a WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br>No  | 16b SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br>164-28-6493   | 17 INFORMANT<br>8201 Watersedge Road<br>Samuel T. Downey, Sr. - Balto, MD. 21222   |   |  |  |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) PNEUMONIA<br>DUE TO, OR AS A CONSEQUENCE OF (b)<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>DUE TO, OR AS A CONSEQUENCE OF (c)  |   |  |   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH                     |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: a<br>CHRONIC LYMPHOCYTIC LEUKEMIA: ANEMIA  |   |  |   |  |  |
| 19a DATE OF OPERATION  | 19b CONDITION FOR WHICH OPERATION WAS PERFORMED   | 20a AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  | 20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |  |
| 21a ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  | 21b TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19   | 21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)   |   |  |  |
| 21d INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK  | 21e PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   | 21f LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |   |  |  |
| 22a I certify that (I) (this hospital) attended the deceased from December 26, 85 to January 16, 85, that (I) (we) last saw the deceased alive on January 16, 85, and that in my (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |   |  |   |  |  |
| 22b SIGNATURE<br>A. F. Nazemi, M.D.  |   | DEGREE   | 22c DATE SIGNED<br>1/16/85  |  |  |
| 22d PHYSICIAN'S NAME (TYPE OR PRINT)<br>A.F. NAZEMI, M.D.  |   | 22e ADDRESS<br>CHURCH HOSPITAL<br>100 N. BROADWAY, BALTO., MD 21231  |   |  |  |
| 23a BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br>Burial  | 23b DATE<br>1/19/1985   | 23c NAME OF CEMETERY OR CREMATORY<br>Oak Lawn  |   | 23d LOCATION<br>CITY OR TOWN COUNTY STATE<br>Baltimore Maryland                                |  |
| 24 FUNERAL DIRECTOR<br>NAME Duda-Ruck, Inc.<br>ADDRESS 7922 Wise Avenue Dundalk, MD. 21222   |   | 25a DATE REC'D. BY REGISTRAR   |   | 25b REGISTRAR'S SIGNATURE<br>JAN 18 1985   |  |

BP

U.S. GOVERNMENT  
PRINTING OFFICE  
WASHINGTON, D.C. 20540



CHIEF OF SECTION

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 5 0 1 5 7 5

1. FOR  
STATE  
REGISTRAR

REG. NO.

|   |   |   |  |  |  |
|---|---|---|--|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>FIRST MIDDLE LAST<br><b>Johnnie A. Starks</b>  |   |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>January 25, 1985</b>         |  | 2b. HOUR<br>M<br><b>M</b>  |
| 3. SEX<br><b>Male</b>   | 4. RACE<br><b>Black</b>   | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>9 23 25</b>  |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>59</b> YRS                                     | IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS.<br>HOURS MIN.   |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>S. Carolina</b>   | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore City</b> MD                     |  |
| 10. CITY OR TOWN OF DEATH<br><b>Baltimore</b>   | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>841 Whitelock St.</b> |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)       |  | 12b. KIND OF BUSINESS OR INDUSTRY  |
| 13a. STATE<br><b>MD</b>   |   |   | 13b. COUNTY  | 13c. CITY OR TOWN<br><b>Baltimore</b>  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                            |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Unknown</b>  |   |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Estelle Rhodes</b> |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>NO</b>   |   | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br><b>247-30-2714</b>   |  | 17. INFORMANT ADDRESS<br><b>Rose Starks 841 Whitelock Street</b>                     |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Metastatic Adenoid Cystic Carcinoma to Lungs</b><br>DUE TO, OR AS A CONSEQUENCE OF (b) <b>Adenoid Cystic Carcinoma Hard Palate</b><br>DUE TO, OR AS A CONSEQUENCE OF (c)<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. |   |   |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH   |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <b>NO</b>  |   |   |  |  |  |
| 19a. DATE OF OPERATION<br><b>10/4/83</b>  |   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED<br><b>Adenoid Cystic Carcinoma Hard Palate</b>   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(* EITHER, NOTIFY MEDICAL EXAMINER)   |   | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)       |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK   |   | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                    |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>OCTOBER</b> , 19 <b>83</b> , to <b>JANUARY 25</b> , 19 <b>85</b> , that (I) (we) lost<br>saw the deceased alive on <b>2-16-</b> 19 <b>85</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated<br>above; (I) (we) (did) (did not) view the body after death.                              |   |   |  |  |  |
| 22b. SIGNATURE<br><b>Harold E. Ramsey</b> MD  |   | DEGREE<br><b>MD</b>   |  | 22c. DATE SIGNED<br><b>1-25-85</b>   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>HAROLD E. RAMSEY</b>  |   | 22e. ADDRESS<br><b>301 McNECHEN ST. BAITO. MD. 21215</b>  |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br><b>CREMATION</b>   | 23b. DATE<br><b>1/30/85</b>   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Westview Mem. Pk.</b>  |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Catonsville, Md.</b>                |  |
| 24. FUNERAL DIRECTOR<br>NAME ADDRESS<br><b>Wm. C. March F/H 1101 E. North Ave.</b>  |   |   | 25a. DATE REC'D. BY REGISTRAR<br><b>JAN 28 1985</b>                    |  |  |
|   |   |   | 25b. REGISTRAR'S SIGNATURE<br><b>Lelia Davidson-Randall</b>            |  |  |

2 8

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be reviewed by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use in the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 5 0 1 5 7 6

REG. NO.

|   |  |  |   |  |  |   |  |  |  |  |  |   |  |                                |  |
|---|--|--|---|--|--|---|--|--|--|--|--|---|--|--------------------------------|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)   |  |  | FIRST MIDDLE LAST   |  |  | 2a. DATE OF DEATH   |  |  | MONTH DAY YEAR   |  |  | 2b. HOUR  |  |                                |  |
| SADIE M. STAUB  |  |  |   |  |  | Jan 9 1985  |  |  |  |  |  | 11:42 PM  |  |                                |  |
| 3. SEX  |  |  | 4. RACE   |  |  | 5. DATE OF BIRTH  |  |  | 6. AGE (IN YEARS LAST BIRTHDAY)                                  |  |  | 7. IF UNDER 1 YEAR                              |  |                                |  |
| FEMALE  |  |  | WHITE   |  |  | MONTH DAY YEAR<br>08 27 1898  |  |  | 86 YRS.  |  |  | IF UNDER 24 HRS.                                |  |                                |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)   |  |  | 7b. CITIZEN OF WHAT COUNTRY?  |  |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  |  | 9. BALTIMORE CITY OR COUNTY OF DEATH                             |  |  |   |  |                                |  |
| MARYLAND  |  |  | U.S.A.  |  |  |   |  |  | BALTIMORE CITY MD.   |  |  |   |  |                                |  |
| 10. CITY OR TOWN OF DEATH   |  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) |  |  |   |  |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE) |  |  | 12b. KIND OF BUSINESS OR INDUSTRY               |  |                                |  |
| BALTIMORE   |  |  | ST. AGNES HOSPITAL  |  |  |   |  |  | HOMEMAKER  |  |  | ---   |  |                                |  |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)   |  |  |   |  |  |   |  |  |  |  |  | 13d. INSIDE CITY LIMITS?                        |  | 13e. STREET ADDRESS / ZIP CODE |  |
| 13a. STATE  |  |  | 13b. CITY OR TOWN   |  |  | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  |  | 21228  |  |  |   |  |                                |  |
| MARYLAND  |  |  | BALTIMORE   |  |  | CATONSVILLE   |  |  | 1204 WESTERLEE PLACE APT. 2B                                     |  |  |   |  |                                |  |
| 14. FATHER'S NAME   |  |  |   |  |  | 15. MOTHER'S MAIDEN NAME  |  |  |  |  |  |   |  |                                |  |
| FIRST MIDDLE LAST<br>CHARLES MEYERS   |  |  |   |  |  | FIRST MIDDLE LAST<br>MARY BAUGHER   |  |  |  |  |  |   |  |                                |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)  |  |  |   |  |  | 16b. SOCIAL SECURITY NO.  |  |  | 17. INFORMANT ADDRESS  |  |  |   |  |                                |  |
| NO  |  |  |   |  |  | 212-36-8820   |  |  | ELIZABETH A. NOLAN 1204 WESTERLEE PLACE APT. 2B 21228            |  |  |   |  |                                |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Cardiopulmonary arrest.</u>  |  |  |   |  |  |   |  |  |  |  |  | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH |  |                                |  |
| DUE TO, OR AS A CONSEQUENCE OF,<br>(b) <u>Ischemic heart disease.</u>   |  |  |   |  |  |   |  |  |  |  |  |   |  |                                |  |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost   |  |  |   |  |  |   |  |  |  |  |  |   |  |                                |  |
| DUE TO, OR AS A CONSEQUENCE OF,<br>(c) _____  |  |  |   |  |  |   |  |  |  |  |  |   |  |                                |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)   |  |  |   |  |  |   |  |  |  |  |  |   |  |                                |  |
| 19a. DATE OF OPERATION  |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  |  | 20a. AUTOPSY?   |  |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?   |  |  |   |  |                                |  |
|   |  |  |   |  |  | YES <input type="checkbox"/> NO <input type="checkbox"/>  |  |  | YES <input type="checkbox"/> NO <input type="checkbox"/>         |  |  |   |  |                                |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |  |  |  |  |  |   |  |                                |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK  |  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                                    |  |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |  |  |  |  |   |  |                                |  |
| 22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) lost<br>saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated<br>above, (I) (we) (did) (did not) view the body after death. |  |  |   |  |  |   |  |  |  |  |  |   |  |                                |  |
| 22b. SIGNATURE<br><u>Adman</u>  |  |  |   |  |  | DEGREE<br>ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>                   |  |  |  |  |  | 22c. DATE SIGNED<br>1/10/85                     |  |                                |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>ARIL P. IMAN.  |  |  |   |  |  | 22e. ADDRESS<br>ST. AGNES HOSPITAL, 900 S. CATON AVENUE   |  |  |  |  |  |   |  |                                |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)  |  |  | 23b. DATE   |  |  | 23c. NAME OF CEMETERY OR CREMATORY  |  |  | 23d. LOCATION  |  |  |   |  |                                |  |
| BURIAL  |  |  | 01-12-85  |  |  | NEW CATHEDRAL   |  |  | BALTIMORE CITY COUNTY STATE<br>MARYLAND                          |  |  |   |  |                                |  |
| 24. FUNERAL DIRECTOR  |  |  |   |  |  | 25a. DATE REC'D. BY REGISTRAR   |  |  | 25b. REGISTRAR'S SIGNATURE                                       |  |  |   |  |                                |  |
| HUBBARD FUNERAL HOME, INC. 4107 WILKENS AVE.  |  |  |   |  |  | 21229   |  |  | JAN 11 1985 <u>Lelia Davidson-Randall</u>                        |  |  |   |  |                                |  |

BP

MS: 11

1892



**STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH**

REG. NO.

|  |  |                      |  |  |  |  |  |   |  |
|--|--|----------------------|--|--|--|--|--|---|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>Marion Steinhorn</b>  |  |                      |  |  |  | 2a. DATE KNOWN OF DEATH<br>ESTIMATED <input checked="" type="checkbox"/> MONTH DAY YEAR <b>1 15 19 85</b>  |  | 2b. HOUR <b>5:30</b>  |  |
| 3. SEX <b>FEMALE</b>   |  | 4. RACE <b>WHITE</b> |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR <b>FEB. 8, 1913</b>                   |  | 6. AGE (IN YEARS)<br>(LAST BIRTHDAY) <b>71</b> YRS.  |  | 7. IF UNDER 1 YR. IF UNDER 24 HRS.  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>PENNSYLVANIA</b>  |  |                      |  | 7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>                                  |  |  |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  |
| 9. BALTIMORE CITY OR COUNTY OF DEATH <b>Baltimore City,</b> MD.  |  |                      |  | 10. CITY OR TOWN OF DEATH <b>Baltimore</b>                               |  |  |  |   |  |
| 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Sinai Hospital</b>   |  |                      |  |  |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>HOUSEWIFE</b>                             |  | 12b. KIND OF BUSINESS OR INDUSTRY <b>AT HOME</b>  |  |
| 13a. STATE <b>MARYLAND</b>   |  |                      |  | 13b. COUNTY <b>BALTIMORE</b>   |  | 13c. CITY OR TOWN <b>BALTIMORE</b>   |  | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  |
| 13e. STREET ADDRESS <b>APT. 106 6314 GREENSPRING AVE.</b>  |  |                      |  | 13f. CITY OR TOWN <b>BALTIMORE</b>                                       |  | 13g. STATE <b>MARYLAND</b>   |  | 13h. ZIP CODE <b>21209</b>  |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST <b>AARON EINSTEIN</b>   |  |                      |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST <b>EMMA UNKNOWN</b>        |  |  |  |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO, OR UNKNOWN) <b>NO</b>  |  |                      |  | 16b. SOCIAL SECURITY NO. <b>213-72-2327</b>                              |  | 17. INFORMANT <b>DR. SYDNEY STEINHORN APT. 106 6314 GREENSPRING AVE. BALTO., MD 21209</b>                  |  |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Barbiturate intoxication</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost.<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____<br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH                         |  |                      |  |  |  |  |  |   |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).  |  |                      |  |  |  |  |  |   |  |
| 19a. DATE OF OPERATION   |  |                      |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?                        |  |  |  | 20. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH   |  |                      |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR <b>? P.M. 12 18 1984</b> |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) <b>Ingested barbiturates</b> |  |   |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/><br>AT WORK AT WORK   |  |                      |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) <b>home</b>  |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE <b>6314 Greenspring Ave, Baltimore City, MD.</b>         |  |   |  |
| 22a. I certify that I took charge of the remains described above, held on death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> Autopsy <input type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion |  |                      |  |  |  |  |  |   |  |
| ACTUAL SIGNATURE <b>Thomas D. Smith</b>  |  |                      |  | TITLE (SPECIFY) <b>Acting Chief</b>                                      |  |  |  | DATE SIGNED <b>1/15/85</b>  |  |
| EXAMINER'S NAME (TYPE OR PRINT) <b>Thomas D. Smith, M.D.</b>   |  |                      |  | ADDRESS <b>111 Penn St. Balto.MD.</b>                                    |  |  |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>BURIAL</b>  |  |                      |  | 23b. DATE <b>JAN.16,1985</b>   |  | 23c. NAME OF CEMETERY OR CREMATORY <b>HEBREW FRIENDSHIP</b>  |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE <b>BALTIMORE MARYLAND</b>  |  |
| 24. FUNERAL DIRECTOR<br>NAME <b>SOL LEVINSON &amp; BROS., INC.</b>   |  |                      |  |  |  | 25a. DATE REC'D. BY REGISTRAR <b>JAN 17 1985</b>   |  | 25b. REGISTRAR'S SIGNATURE <b>Jana Davidson</b>   |  |
| 6010 REISTERSTOWN RD. BALTO., MD 21215   |  |                      |  |  |  |  |  |   |  |

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 3 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

07/84  
25M

BP

DHMH - 17  
(VR A15 ME (5))

CONFIDENTIAL

SECRET



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. GIVE PAGE 4 TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR OFFICE. IF THIS CERTIFICATE IS TO BE USED AS A BURIAL - TRANSIT PERMIT, PAGES 1 AND 2 SHOULD BE FILED, WITHIN 7 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

07/84  
25M

BP

DHMH - 17  
(VR A15 ME (5))

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

|   |         |   |  |  |  |   |  |   |                                   |                          |  |   |  |
|---|---------|---|--|--|--|---|--|---|-----------------------------------|--------------------------|--|---|--|
| 1- FOR STATE REGISTRAR  |         | 2a. DATE KNOWN OF DEATH <input checked="" type="checkbox"/> MONTH DAY YEAR                              |  |  |  |   |  |   |                                   |                          |  | 2b. HOUR  |  |
| 1. DECEASED NAME (TYPE OR PRINT)  |         | FIRST   |  | MIDDLE   |  | LAST  |  | 2c. DATE ESTI-MATED <input type="checkbox"/> MONTH DAY YEAR |                                   | 2d. HOUR                 |  |   |  |
| M. KENNETH STEMM  |         |   |  |  |  |   |  | 1/ 3/ 19 85   |                                   | M                        |  |   |  |
| 3. SEX  | 4. RACE | 5. DATE OF BIRTH  |  | 6. AGE (IN YEARS)  |  | IF UNDER 1 YR.  |  | IF UNDER 24 HRS.  |                                   | 7c. DATE PRONOUNCED DEAD |  |   |  |
| M   | W       | 1/3/17  |  | 68 YRS.  |  |   |  |   |                                   | 1/ 3/ 19 85              |  |   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)   |         | 7b. CITIZEN OF WHAT COUNTRY?  |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH  |  |   |                                   |                          |  |   |  |
| MD  |         | USA   |  |  |  | Baltimore City, MD  |  |   |                                   |                          |  |   |  |
| 10. CITY OR TOWN OF DEATH   |         | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) |  |  |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)                     |  |   | 12b. KIND OF BUSINESS OR INDUSTRY |                          |  |   |  |
| Baltimore   |         | 3100 N. Calvert St.   |  |  |  | Vice President  |  |   | Bank                              |                          |  |   |  |
| 13a. STATE  |         | 13b. COUNTY   |  | 13c. CITY OR TOWN  |  | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/> |  | 13e. STREET ADDRESS   |                                   |                          |  |   |  |
| MD  |         |   |  | Baltimore  |  |   |  | 3100 N. Calvert St., 21218                                  |                                   |                          |  |   |  |
| 14. FATHER'S NAME   |         |   |  | 15. MOTHER'S MAIDEN NAME   |  |   |  |   |                                   |                          |  |   |  |
| FIRST MIDDLE LAST   |         |   |  | FIRST MIDDLE LAST  |  |   |  |   |                                   |                          |  |   |  |
| Mehrl   |         |   |  | Stemm  |  |   |  | Ethel Dettmer   |                                   |                          |  |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)  |         | 16b. SOCIAL SECURITY NO.  |  | 17. INFORMANT  |  |   |  | ADDRESS   |                                   |                          |  |   |  |
| No  |         | 218 01 9026   |  | Lavinia R. Stemm,  |  |   |  | Same  |                                   |                          |  |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)   |         |   |  |  |  |   |  |   |                                   |                          | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |   |  |
| PART I DEATH WAS CAUSED BY:   |         |   |  |  |  |   |  |   |                                   |                          |  |   |  |
| IMMEDIATE CAUSE (a) <u>Arteriosclerotic Cardiovascular Disease</u>  |         |   |  |  |  |   |  |   |                                   |                          |  |   |  |
| DUE TO, OR AS A CONSEQUENCE OF  |         |   |  |  |  |   |  |   |                                   |                          |  |   |  |
| Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.   |         |   |  |  |  |   |  |   |                                   |                          |  |   |  |
| (b) _____   |         |   |  |  |  |   |  |   |                                   |                          |  |   |  |
| DUE TO, OR AS A CONSEQUENCE OF  |         |   |  |  |  |   |  |   |                                   |                          |  |   |  |
| (c) _____   |         |   |  |  |  |   |  |   |                                   |                          |  |   |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).   |         |   |  |  |  |   |  |   |                                   |                          |  |   |  |
| <u>Epileptic Seizure Disorder</u>   |         |   |  |  |  |   |  |   |                                   |                          |  |   |  |
| 19a. DATE OF OPERATION  |         | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?   |  |  |  |   |  |   |                                   |                          |  | 20. AUTOPSY?  |  |
|   |         |   |  |  |  |   |  |   |                                   |                          |  | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH   |         | 21b. TIME OF INJURY   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)  |  |   |  |   |                                   |                          |  |   |  |
|   |         | HOUR A.M. MONTH DAY YEAR  |  |  |  |   |  |   |                                   |                          |  |   |  |
|   |         | P.M. 19   |  |  |  |   |  |   |                                   |                          |  |   |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK   |         | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)   |  | 21f. LOCATION  |  | CITY OR TOWN  |  | COUNTY  |                                   | STATE                    |  |   |  |
|   |         |   |  |  |  |   |  |   |                                   |                          |  |   |  |
| 22a. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: <u>Natural Causes</u> <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> . |         |   |  |  |  |   |  |   |                                   |                          |  |   |  |
| ACTUAL SIGNATURE  |         | TITLE (SPECIFY)   |  |  |  |   |  | DATE SIGNED   |                                   |                          |  |   |  |
|   |         | M.D. Assistant MEDICAL EXAMINER   |  |  |  |   |  | 1/4/85  |                                   |                          |  |   |  |
| EXAMINER'S NAME (TYPE OR PRINT)   |         | ADDRESS   |  |  |  |   |  |   |                                   |                          |  |   |  |
| G. Kauffman, MD   |         | 111 Penn St., Balto., MD  |  |  |  |   |  |   |                                   |                          |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)   |         | 23b. DATE   |  | 23c. NAME OF CEMETERY OR CREMATORY   |  | 23d. LOCATION (CITY OR TOWN)  |  | COUNTY  |                                   | STATE                    |  |   |  |
| Burial  |         | 1/7/85  |  | Pipe Creek   |  | Carroll County,   |  |   |                                   | MD                       |  |   |  |
| 24. FUNERAL DIRECTOR NAME   |         |   |  | 25a. DATE REC'D. BY REGISTRAR  |  |   |  | 25b. REGISTRAR'S SIGNATURE                                  |                                   |                          |  |   |  |
| Henry W. Jenkins & Sons Co.   |         |   |  | JAN 4 1985   |  |   |  | John Davidson-Russell                                       |                                   |                          |  |   |  |
| 4905 York Road Balto., MD 21212   |         |   |  |  |  |   |  |   |                                   |                          |  |   |  |

1950 York Road, Elio., ME 04111  
Henry W. Jenkins & Sons Co.  
1775 Pine Street  
Portland, ME 04105

Control County, ME  
111 Bond St., Elio., ME



OTTO  
%  
no

No 218 of 1950 Lavinia R. Connors, Maine

Wahnet, Connors, Elio.

MD, Elio., Connors, Elio.

31 N. O. Bond St., Elio., ME 04111  
Vice President, Elio.

USA, Elio.

1775 Pine Street, Elio.

Wahnet, Elio.

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 5 0 1 5 7 9

FOR  
1 - STATE  
REGISTRAR

REG. NO.

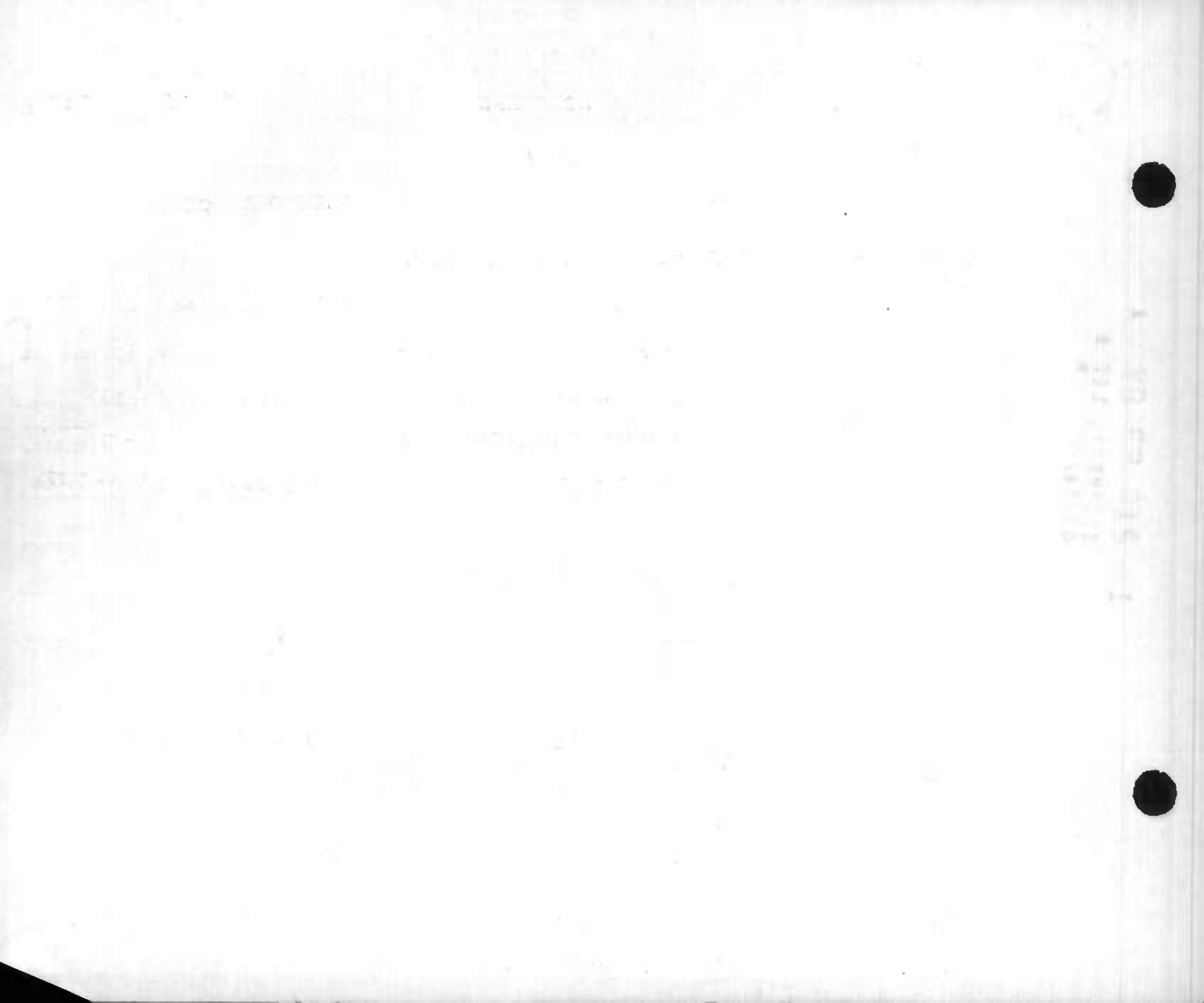
|  |  |   |  |  |   |
|--|--|---|--|--|---|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br><b>LEE A STEPHENS</b>   |  |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>01 28 85</b>               |  | 2b. HOUR<br><b>2:00pm</b>   |
| 3. SEX<br><b>Female</b>  | 4. RACE<br><b>Black</b>  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>3/4/30</b>   |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>54</b> YRS.<br>IF UNDER 1 YEAR: MONTHS DAYS<br>IF UNDER 24 HRS: HOURS MIN. |   |
| 7a. BIRTHPLACE<br>(COUNTRY)<br><b>Va.</b>  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>   | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>BALTIMORE CITY</b> MD.  |   |
| 10. CITY OR TOWN OF DEATH<br><b>BALTIMORE</b>  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>THE JOHNS HOPKINS HOSPITAL</b> |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)     |  | 12b. KIND OF BUSINESS OR INDUSTRY   |
| 13a. STATE<br><b>Md.</b>   |  |   | 13b. COUNTY<br><b>Balto.</b>   | 13c. CITY OR TOWN<br><b>Balto.</b>   | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                               |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Ernest Owens</b>  |  |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Thelma Morly</b> |  |   |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>No</b>  |  | 16b. SOCIAL SECURITY NO.<br><b>224-36-1590</b>  |  | 17. INFORMANT ADDRESS<br><b>Quandra Stephens 535 Cumberland St.</b>  |   |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>CARDIO PULMONARY Arrest</b><br>DUE TO, OR AS A CONSEQUENCE OF (b) <b>METASTATIC Breast Carcinoma</b><br>DUE TO, OR AS A CONSEQUENCE OF (c) <b>Central Nervous System Metastasis</b>  |  |   |  |  | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH<br><b>5-7 months</b><br><b>18 months</b>                                      |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)  |  |   |  |  |   |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                             | 20b. IF YES, WERE FINDINGS USED<br>IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>11:20</b> <b>85</b> <b>19</b>   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)                                   |   |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> AT WORK<br>NOT WHILE <input type="checkbox"/> AT WORK   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE  |   |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>1/28</b> , 19 <b>85</b> , to <b>1/28</b> , 19 <b>85</b> , that (I) (we) last saw the deceased alive on <b>1/28</b> , 19 <b>85</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |  |   |  |  |   |
| 22b. SIGNATURE<br><b>Eric Rowinsky</b>   |  | DEGREE<br>ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>        |  | 22c. DATE SIGNED<br><b>1/28/88</b>   |   |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>ERIC ROWINSKY MD</b>   |  | 22e. ADDRESS<br><b>Johns Hopkins Hospital</b>   |  |  |   |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>Cremation</b>   |  | 23b. DATE<br><b>2/4/85</b>  |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Westview Cem.</b>   |   |
| 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Baltimore Md.</b>   |  | 23e. DATE REC'D. BY REGISTRAR<br><b>IAN 30 1985</b>   |  |  |   |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>Wm. C. March F/H 1101 E. North Ave.</b>   |  | 25b. REGISTRAR'S SIGNATURE  |  |  |   |

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be completed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the funeral director, it must be completely filled in by the funeral director. Page 5 should be detached for use as the burial-transit permit. Then place in the container with the deceased. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 12 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH   |  |  |  |  |  |  |  |  |  | REG. NO.  |  |                |  |          |  |    |  |  |  |  |  |  |  |  |  |  |                                |  |  |   |  |  |  |  |  |  |  |  |  |
|--|--|--|--|--|--|--|--|--|--|---|--|----------------|--|----------|--|----|--|--|--|--|--|--|--|--|--|--|--------------------------------|--|--|---|--|--|--|--|--|--|--|--|--|
| 1. FOR<br>STATE<br>REGISTRAR   |  |  |  |  | 1. DECEASED NAME<br>(TYPE OR PRINT)                                    |  |  |  |  | 2a. DATE OF DEATH   |  | MONTH DAY YEAR |  | 2b. HOUR |  | PM |  |  |  |  |  |  |  |  |  |  |                                |  |  |   |  |  |  |  |  |  |  |  |  |
| FIRST MIDDLE LAST<br>Willie T. STEPHENS  |  |  |  |  | 3. SEX<br>Male   |  |  |  |  | 4. RACE<br>Black  |  |                |  |          | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>February 3, 1901   |    |  |  |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br>83 YRS.   |  |  |  |  | IF UNDER 1 YEAR<br>MONTHS DAYS   |  | IF UNDER 24 HRS.<br>HOURS MIN. |  |  |   |  |  |  |  |  |  |  |  |  |
| 7a. BIRTHPLACE<br>(STATE OR FOREIGN COUNTRY)<br>Virginia   |  |  |  |  | 7b. CITIZEN OF WHAT COUNTRY?<br>USA                                    |  |  |  |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  |                |  |          | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Baltimore, MD  |    |  |  |  | 10. CITY OR TOWN OF DEATH<br>Baltimore   |  |  |  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>4517 Reistertown Road |  |                                |  |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Retired |  |  |  |  | 12b. KIND OF BUSINESS OR INDUSTRY<br>n/a |  |  |  |  |
| 13a. STATE<br>Md   |  |  |  |  | 13b. COUNTY<br>Baltimore   |  |  |  |  | 13c. CITY OR TOWN<br>Baltimore  |  |                |  |          | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>  |    |  |  |  | 13e. STREET ADDRESS<br>4517 Reistertown Road 71215   |  |  |  |  | 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>George Stephens  |  |                                |  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Josephine Coleman          |  |  |  |  |  |  |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br>No   |  |  |  |  | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br>578-28-9571 |  |  |  |  | 17. INFORMANT<br>ADDRESS<br>Sharifah Bey 4517 Reistertown Rd.   |  |                |  |          | 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>CARDIAL ARRHYTHMIA</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last:<br>(b) <u>ARTHEROSCLEROTIC HEART DISEASE</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <u>CORONARY ATHEROSCLEROSIS</u><br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><u>IMMEDIATE</u> |    |  |  |  | PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <u>5 Adenocarcinoma of the Lung</u> |  |  |  |  |  |  |                                |  |  |   |  |  |  |  |  |  |  |  |  |
| 19a. DATE OF OPERATION   |  |  |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                       |  |  |  |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>   |  |                |  |          | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>   |    |  |  |  |  |  |  |  |  |  |  |                                |  |  |   |  |  |  |  |  |  |  |  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  |  |  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19             |  |  |  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |  |                |  |          | 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>   |    |  |  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |  |  |  |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE  |  |                                |  |  |   |  |  |  |  |  |  |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from Jan 12, 1985, to Jan 25, 1985, that (I) (we) lost<br>saw the deceased alive on 1-25-85, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated<br>above, (I) (we) (did) (did not) view the body after death. |  |  |  |  | 22b. SIGNATURE<br><i>John J. Jakubovics</i>                            |  |  |  |  | DEGREE<br>MD  |  |                |  |          | 22c. DATE SIGNED<br>1-29-85  |    |  |  |  |  |  |  |  |  |  |  |                                |  |  |   |  |  |  |  |  |  |  |  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>J. JAKUBOVICS   |  |  |  |  | 22e. ADDRESS<br>501 LANIER AVE, Balto. Md 21215                        |  |  |  |  | 23a. BURIAL, CREMATION, REMOVAL<br>(STATE)<br>Burial  |  |                |  |          | 23b. DATE<br>2-2-85  |    |  |  |  | 23c. NAME OF CEMETERY OR CREMATORY<br>Lincoln Mem. Cemetery  |  |  |  |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Suitland, Md.  |  |                                |  |  |   |  |  |  |  |  |  |  |  |  |
| 24. FUNERAL DIRECTOR<br>NAME<br>Marshall's Funeral Home  |  |  |  |  | 24b. ADDRESS<br>4217 9th St NW: Washington, D.C.                       |  |  |  |  | 25a. DATE REC'D. BY REGISTRAR<br>FEB 04 1985  |  |                |  |          | 25b. REGISTRAR'S SIGNATURE<br><i>John Davidson-Randall</i>   |    |  |  |  |  |  |  |  |  |  |  |                                |  |  |   |  |  |  |  |  |  |  |  |  |

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STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 5 0 1 5 8 1

FOR  
STATE  
REGISTRAR

REG. NO.

|   |  |   |  |   |  |   |  |   |  |  |
|---|--|---|--|---|--|---|--|---|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT) <i>Estella Florence stepney</i>   |  |   | 2a. DATE OF DEATH MONTH DAY YEAR<br><i>11/31/85</i>            |   |  | 2b. HOUR<br><i>2:45 P.M.</i>  |  |   |  |  |
| 3. SEX<br><i>Female</i>   |  | 4. RACE<br><i>Black</i>   |  | 5. DATE OF BIRTH MONTH DAY YEAR<br><i>02/28/93</i>  |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><i>91</i> YRS.   |  |   |  |  |
| 7b. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><i>Balto. Md</i>   |  | 7c. CITIZEN OF WHAT COUNTRY?<br><i>U.S.A.</i>   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><i>Balto. City</i> MD.  |  |   |  |  |
| 10. CITY OR TOWN OF DEATH<br><i>Baltimore</i>   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) |  |   |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><i>Housewife</i>  |  | 12b. KIND OF BUSINESS OR INDUSTRY   |  |  |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)   |  |   |  |   |  |   |  |   |  |  |
| 13a. STATE<br><i>Md</i>   |  | 13b. COUNTY   |  | 13c. CITY OR TOWN<br><i>Balto.</i>  |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>   |  | 13e. STREET ADDRESS / ZIP CODE<br><i>3422 Bashman Ave 21215</i>   |  |  |
| 14. FATHER'S NAME FIRST MIDDLE LAST<br><i>Lois GIPSON</i>   |  |   |  | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST<br><i>ANNABELL R Johnson</i>   |  |   |  |   |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><i>No</i>   |  |   |  | 16b. SOCIAL SECURITY NO.  |  | 17. INFORMANT ADDRESS<br><i>ELSIE FANT 2929 Fairview Rd</i>   |  |   |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line (a), (b), and (c))  |  |   |  |   |  |   |  |   |  |  |
| PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a): <i>Cardio-pulmonary arrest</i>   |  |   |  |   |  |   |  |   |  |  |
| DUE TO, OR AS A CONSEQUENCE OF (b): <i>Bladder CA - Renal failure</i>   |  |   |  |   |  |   |  |   |  |  |
| DUE TO, OR AS A CONSEQUENCE OF (c): <i>malnutrition - multiple decubiti.</i>  |  |   |  |   |  |   |  |   |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I.<br><i>Splais, fistula at old site of gastrostomy</i> |  |   |  |   |  |   |  |   |  |  |
| 19a. DATE OF OPERATION<br><i>1/22/85</i>  |  |   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED               |   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |  |
| 21a. INCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)                                 |  |   | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR<br><i>P.M. 19</i> |   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |  |   | 21d. INJURY OCCURRED<br>WHERE <input type="checkbox"/> AT HOME <input type="checkbox"/> AT WORK <input type="checkbox"/> |  |
| 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |  |   | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE                 |   |  | 21g. I certify that (I) (this hospital) attended the deceased from 19__ to 19__, that (I) (we) last saw the deceased alive on 19__, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (and I) (and I) saw the body after death. |  |   |  |  |
| 22a. SIGNATURE<br><i>Jean Albert Midy MD</i>  |  |   | 22b. DEGREE<br><i>MD, FICS</i>                                 |   |  | 22c. ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>  |  |   | 22d. DATE SIGNED   |  |
| 23a. PHYSICIAN'S NAME   |  |   | 23b. ADDRESS<br><i>549 N Fulton Ave, Balto MD 21223</i>        |   |  | 23c. NAME OF CEMETERY OR CREMATORY<br><i>Arboretum</i>  |  |   | 23d. LOCATION CITY OR TOWN COUNTY STATE<br><i>Arboretum Md</i>   |  |
| 24. BURIAL, CREMATION, REMOVAL (SPECIFY)  |  |   | 24a. DATE<br><i>2/5/85</i>                                     |   |  | 24b. NAME OF CEMETERY OR CREMATORY<br><i>Arboretum</i>  |  |   | 24c. LOCATION CITY OR TOWN COUNTY STATE<br><i>Arboretum Md</i>   |  |
| 24d. FUNERAL DIRECTOR<br><i>Locke Funeral Home 1304 N. Central St</i>   |  |   | 24e. DATE REC'D. BY REGISTRAR<br><i>FEB 4 1985</i>             |   |  | 24f. REGISTRAR'S SIGNATURE<br><i>J. W. Williams</i>   |  |   | 24g. REGISTRAR'S SIGNATURE   |  |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use on the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after burial with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.



STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH1- FOR  
STATE  
REGISTRAR

REG. NO.

|  |  |  |  |   |  |   |  |
|--|--|--|--|---|--|---|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>FIRST MIDDLE LAST<br><b>EDWIN STEWART</b> |  |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>01 15 85</b> |   |  | 2b. HOUR<br><b>12 15 P.M.</b>   |  |
| 3. SEX<br><b>Male</b>  |  | 4. RACE<br><b>BLACK</b>  |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>07 30 04</b>   |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>80</b> YRS.                                 |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Jamaica Port Antonio</b>         |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore City MD.</b>                 |  |
| 10. CITY OR TOWN OF DEATH<br><b>Baltimore</b>                                    |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Francis Scott Key Med. Center</b> |  |   |  | 12a. USUAL OCCUPATION (NATURE OF WORK FOR MOST OF WORKING LIFE)<br><b>Retired</b> |  |
| 13a. STATE<br><b>Md.</b>   |  | 13b. COUNTY<br><b>Baltimore</b>  |  | 13c. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>   |  | 13d. STREET ADDRESS<br><b>201 N. Washington St.</b>                               |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>JAMES STEWART</b>                   |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Adela</b>  |  | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)   |  |   |  |
| 16b. SOCIAL SECURITY NO.<br><b>216-26-6315</b>                                   |  | 17. INFORMANT<br>NAME ADDRESS<br><b>KAREEM Richards 406 N. Castle St.</b>  |  |   |  |   |  |

## 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) **CARDIO PULMONARY ARREST**

DUE TO, OR AS A CONSEQUENCE OF

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.

(b) **ACUTE RENAL FAILURE**

DUE TO, OR AS A CONSEQUENCE OF

(c)

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

## PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 11a.

|   |  |  |  |  |  |  |  |
|---|--|--|--|--|--|--|--|
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                       |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>  |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19             |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)   |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE  |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>JAN 11</b> , 19 <b>85</b> , to <b>JAN 15</b> , 19 <b>85</b> , that (I) (we) lost <b>above</b> <b>(I) (we) (did) did not</b> view the body after death, and that in <b>(my) (our)</b> opinion death occurred on the date and hour and from the causes stated |  |  |  |  |  |  |  |
| 22b. SIGNATURE<br><b>Mitchell J. Cohen</b>  |  | DEGREE<br><b>MD</b>  |  | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |  | 22c. DATE SIGNED<br><b>1/15/85</b>   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>Mitchell J. Cohen</b>   |  | MD   |  | 22e. ADDRESS<br><b>4480 Eastern Ave Balto, MD</b>  |  |  |  |

|  |  |  |  |  |  |  |  |
|--|--|--|--|--|--|--|--|
| 23a. BURIAL, CREMATION, REMOVAL<br><b>BURIAL</b>     |  | 23b. DATE<br><b>1-19-85</b>            |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>KENY PARK</b> |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Baltimore Md.</b> |  |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>Irvin Carroll</b> |  | ADDRESS<br><b>1712-14 W. North Ave</b> |  | DATE REC'D. BY REGISTRAR<br><b>JAN 22 1985</b>         |  | REGISTRAR'S SIGNATURE<br><b>Julia Davidson-Henderson</b>           |  |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon copies. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM-3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>MEDICAL EXAMINER'S CERTIFICATE OF DEATH  |  |  |  |   |  |  |  |   |  | REG. NO.  |  |
|--|--|--|--|---|--|--|--|---|--|---|--|
| 1. DECEASED NAME (TYPE OR PRINT)<br>FIRST MIDDLE LAST<br><b>Shirley Marie Stewart</b>  |  |  |  |   |  |  |  |   |  | 2a. DATE KNOWN OF DEATH<br>ESTIMATED <input checked="" type="checkbox"/> MONTH DAY YEAR<br><b>1 8 19 85</b> |  |
| 1. SEX<br><b>Female</b>  |  | 4. RACE<br><b>Black</b>  |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>5 30 1941</b>  |  | 6. AGE (IN YEARS)<br>LAST BIRTHDAY<br><b>43 YRS.</b>   |  | IF UNDER 24 HRS.<br>MONTHS DAYS HOURS MIN.<br><b>24 00 00 00</b>                      |  | 2c. DATE PRONOUNCED DEAD<br>MONTH DAY YEAR<br><b>1 8 19 85</b>  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Maryland</b>   |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U. S. A.</b>  |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore City, MD.</b>                               |  |   |  |   |  |
| 11. CITY OR TOWN OF DEATH<br><b>Baltimore</b>  |  | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>4711 Navarro Avenue</b> |  |   |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Representative</b>           |  | 12b. KIND OF BUSINESS<br><b>Housing</b>   |  |   |  |
| 13a. STATE<br><b>Maryland</b>  |  | 13b. COUNTY  |  | 13c. CITY OR TOWN<br><b>Baltimore</b>   |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>  |  | 13e. STREET ADDRESS<br><b>4711 Navarro Avenue</b><br><b>Baltimore, Maryland 21215</b> |  |   |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Shelton Stewart Sr.</b>   |  |  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Christianna Smallwood</b>   |  |  |  |   |  |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO, OR UNKNOWN)<br><b>No.</b>  |  |  |  | 16b. SOCIAL SECURITY NO.<br><b>214-38-1919</b>  |  | 17. INFORMANT<br><b>Christanna Stewart</b><br><b>2408 W. Lafayette Ave. Baltimore, Md. 21216</b> |  |   |  |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Cirrhosis of liver &amp; Chronic pancreatitis</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost.<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____  |  |  |  |   |  |  |  |   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH  |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I   |  |  |  |   |  |  |  |   |  |   |  |
| 19a. DATE OF OPERATION   |  |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?   |  |  |  |   |  | 20. AUTOPSY?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                         |  |
| 21a. EXTERNAL CAUSE WAS<br>UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH   |  |  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)                    |  |   |  |   |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>   |  |  |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)   |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE  |  |   |  |   |  |
| 22a. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> . |  |  |  |   |  |  |  |   |  |   |  |
| ACTUAL SIGNATURE<br><i>Margarita A. Korell</i>   |  |  |  | TITLE (SPECIFY)<br><b>M.D. Assistant</b>  |  |  |  | DATE SIGNED<br><b>1/9/85</b>  |  |   |  |
| EXAMINER'S NAME (TYPE OR PRINT)<br><b>Margarita A. Korell, M.D.</b>  |  |  |  | ADDRESS<br><b>111 Penn St. Balto., MD.</b>  |  |  |  |   |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>Burial</b>   |  |  |  | 23b. DATE<br><b>1/12/1985</b>   |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Arbutus Memorial Park</b>                               |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Baltimore, Maryland</b>              |  |   |  |
| 24. FUNERAL DIRECTOR<br>NAME ADDRESS<br><b>Nutter &amp; Sons 2501 Gwynns Falls Parkway</b><br><b>Funeral Home Inc. Baltimore, Maryland 21216</b>   |  |  |  |   |  | 25a. DATE REC'D. BY REGISTRAR<br><b>JAN 17 1985</b>  |  | 25b. REGISTRAR'S SIGNATURE  |  |   |  |





TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM VM-3. RETAIN PAGE 5. OR YOUR FILES TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>MEDICAL EXAMINER'S CERTIFICATE OF DEATH   |                         |  |  |   |                                |   |  |   |  | REG. NO. |  |
|---|-------------------------|--|--|---|--------------------------------|---|--|---|--|----------|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT) FIRST MIDDLE LAST<br><b>HARRY E. STEYERT</b>  |                         |  |  |   |                                | 2a. DATE KNOWN OF DEATH ESTIMATED<br><input checked="" type="checkbox"/> MONTH DAY YEAR<br><b>1-25-85</b> |  | 2b. HOUR<br><b>10:04</b>  |  |          |  |
| 3. SEX<br><b>Male</b>   | 4. RACE<br><b>White</b> | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>Oct. 12, 1894</b>   | 6. AGE (IN YEARS)<br>LAST BIRTHDAY<br><b>90</b> YRS. | IF UNDER 1 YR.<br>MONTHS DAYS   | IF UNDER 24 HRS.<br>HOURS MIN. | 2c. DATE PRONOUNCED DEAD<br><b>1-25-85</b>  |  | 2d. HOUR<br><b>10:04</b>  |  |          |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Pa.</b>   |                         | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>  |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |                                | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore City</b> MD.   |  |   |  |          |  |
| 10. CITY OR TOWN OF DEATH<br><b>Baltimore</b>   |                         | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Union Memorial Hospital</b> |  |   |                                | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Sales</b>                             |  | 12b. KIND OF BUSINESS OR INDUSTRY   |  |          |  |
| 13a. STATE<br><b>Md.</b>  |                         | 13b. COUNTY  |  | 13c. CITY OR TOWN<br><b>Baltimore</b>   |                                | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>           |  | 13e. STREET ADDRESS<br><b>6605 Hampnett Ave. 21214</b>                              |  |          |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Harry Steyert</b>  |                         |  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Phoebe Briegel</b>  |                                |   |  |   |  |          |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO, OR UNKNOWN)<br><b>Yes</b>   |                         | 16b. SOCIAL SECURITY NO.<br><b>140-03-7846</b>   |  | 17. INFORMANT<br>ADDRESS<br><b>Harry D. Steyert 6605 Hampnett Ave.</b>  |                                |   |  |   |  |          |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Dissecting thoracic aortic aneurysm</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____   |                         |  |  |   |                                |   |  |   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |          |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).   |                         |  |  |   |                                |   |  |   |  |          |  |
| 19a. DATE OF OPERATION  |                         | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?  |  |   |                                |   |  | 20. AUTOPSY?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |          |  |
| 21a. EXTERNAL CAUSE WAS<br>UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH  |                         | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)   |                                |   |  |   |  |          |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>  |                         | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)  |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |                                |   |  |   |  |          |  |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: <b>Natural causes</b> <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> |                         |  |  |   |                                |   |  |   |  |          |  |
| ACTUAL SIGNATURE<br><b>Margareta Ore Hall</b>   |                         |  |  | TITLE (SPECIFY)<br><b>M.D. Assistant</b>  |                                |   |  | DATE SIGNED<br><b>1-26-85</b>   |  |          |  |
| EXAMINER'S NAME<br>(TYPE OR PRINT)<br><b>Margarita A. Korell, M.D.</b>  |                         |  |  | ADDRESS<br><b>111 Penn Street</b>   |                                |   |  |   |  |          |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>Burial</b>   |                         | 23b. DATE<br><b>1-28-85</b>  |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Parkwood</b>   |                                | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Baltimore, Maryland</b>                                  |  |   |  |          |  |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>Leonard J. Ruck, Inc.</b>  |                         |  |  | ADDRESS<br><b>5305 Harford Rd. 21214</b>  |                                | 25a. DATE REC'D. BY REGISTRAR<br><b>JAN 28 1985</b>   |  | 25b. REGISTRAR'S SIGNATURE<br><b>J. Davidson-Randell</b>                            |  |          |  |

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**STATE OF MARYLAND**  
**DEPARTMENT OF HEALTH AND MENTAL HYGIENE**  
**CERTIFICATE OF DEATH**

8 5 0 1 5 8 5

1. FOR  
STATE  
REGISTRAR

REG. NO.

|   |  |   |                     |   |  |   |                                   |   |
|---|--|---|---------------------|---|--|---|-----------------------------------|---|
| 1. DECEASED NAME<br>(TYPE OR PRINT)   |  | FIRST<br><b>LaRue</b>   | MIDDLE<br><b>O.</b> | LAST<br><b>Stine</b>  | 2a. DATE OF DEATH MONTH DAY YEAR<br><b>Jan. 17, 1985</b>                             |   | 2b. HOUR<br><b>6:15</b> P M       |   |
| 3. SEX<br><b>Female</b>   |  | 4. RACE<br><b>White</b>   |                     | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>Aug. 5 1928</b>  |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>56</b> YRS  |                                   | IF UNDER 1 YEAR<br>MONTHS DAYS                              |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Pennsylvania</b>                  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>   |                     | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore City</b> MD.                               |                                   |   |
| 10. CITY OR TOWN OF DEATH<br><b>Baltimore</b>                                     |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Good Samaritan Hospital</b> |                     |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Housewife</b> |   | 12b. KIND OF BUSINESS OR INDUSTRY |   |
| 13a. STATE<br><b>Penna.</b>   |  | 13b. COUNTY<br><b>Franklin</b>  |                     | 13c. CITY OR TOWN<br><b>Waynesboro</b>  |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |                                   | 13e. STREET ADDRESS<br><b>812 Anthony Ave.</b> <b>17268</b> |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>William P. Niedentohl</b>            |  |   |                     | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Anna M. Harrison</b>  |  |   |                                   |   |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>No</b> |  | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br><b>225-30-1795</b>   |                     | 17. INFORMANT<br><b>Preston R. Stine</b>  |  | ADDRESS <b>Waynesboro, Pa. 812 Anthony Ave. 17268</b>   |                                   |   |

|   |  |   |  |
|---|--|---|--|
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Cardiopulmonary arrest</b> |  | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH |  |
| DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which<br>gave rise to immediate<br>cause (a), stating the<br>underlying cause last.                     |  | (b)   |  |
| DUE TO, OR AS A CONSEQUENCE OF<br>(c)   |  |   |  |

|   |  |  |  |
|---|--|--|--|
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: (a)<br><b>Pneumonia, infected hip, arthritis</b>   |  |  |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  |
| 20a. AUTOPSY?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>  |  | 20b. IF YES, WERE FINDINGS USED<br>IN CERTIFYING CAUSES OF DEATH?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>  |  |
| 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)   |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |  |
| 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>11/14</b> , 19 <b>85</b> , to <b>11/17</b> , 19 <b>85</b> , that (I) (we) lost<br>saw the deceased alive on <b>11/17</b> , 19 <b>85</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated<br>above, (I) (we) (did) (did not) view the body after death. |  |  |  |
| 22b. SIGNATURE<br><b>Mark Strobino</b>  |  | 22c. DATE SIGNED<br><b>1/17/85</b>   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>Mark Strobino</b>   |  | 22e. ADDRESS<br><b>Good Samaritan Hospital, Baltimore, Md.</b>   |  |

|   |  |                               |  |  |  |   |  |
|---|--|-------------------------------|--|--|--|---|--|
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>Burial</b> |  | 23b. DATE<br><b>1/21/1985</b> |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Green Hill Cemetery</b> |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Waynesboro Franklin Penna.</b> |  |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>David M. Giese</b>         |  |                               |  | ADDRESS<br><b>Waynesboro, Penna.</b>                             |  | 25a. DATE REC'D. BY REGISTRAR<br><b>JAN 22 1985</b>                             |  |
| 25b. REGISTRAR'S SIGNATURE<br><b>John Davidson-Randall</b>    |  |                               |  |  |  |   |  |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 5 0 1 5 8 6

1. FOR  
STATE  
REGISTRAR

REG. NO.

|   |  |  |   |   |  |   |  |  |  |   |  |
|---|--|--|---|---|--|---|--|--|--|---|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>FREDERICK C. STOFFEL</b>                       |  |  | 2a. DATE OF DEATH<br>MONTH <b>1</b> DAY <b>6</b> YEAR <b>85</b> |   |  | 2b. HOUR<br><b>9.40 AM</b>  |  |  |  |   |  |
| 3. SEX<br><b>MALE</b>   |  | 4. RACE<br><b>WHITE</b>  |   | 5. DATE OF BIRTH<br>MONTH <b>8</b> DAY <b>16</b> YEAR <b>1902</b>   |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>82</b> YRS  |  | 7. IF UNDER 1 YEAR<br>MONTHS <b>3</b> DAYS <b>2</b>                    |  | 7. IF UNDER 24 HRS<br>HOURS <b>9</b> MIN. <b>40</b> |  |
| 7b. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Pennsylvania PA</b>                   |  | 7c. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>  |   | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore</b> MD.                                    |  |  |  |   |  |
| 10. CITY OR TOWN OF DEATH<br><b>Baltimore</b>   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Mercy Hospital</b> |   |   |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Chef</b>                 |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>Harry M. Stevens &amp; Co.</b> |  |   |  |
| 13a. STATE<br><b>Maryland</b>   |  | 13b. COUNTY  |   | 13c. CITY OR TOWN<br><b>Baltimore</b>   |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 13e. STREET ADDRESS<br><b>16 S. Patterson Park Ave. 21231</b>          |  |   |  |
| 14. FATHER'S NAME<br>FIRST <b>Frederick</b> MIDDLE <b>Stoffel</b> LAST <b>Stoffel</b> |  |  |   | 15. MOTHER'S MAIDEN NAME<br>FIRST <b>Mamie</b> MIDDLE <b>Walters</b> LAST <b>Walters</b>  |  |   |  |  |  |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) <b>NO</b>        |  | 16b. SOCIAL SECURITY NO.<br><b>217-07-7213</b>   |   | 17. INFORMANT<br>ADDRESS <b>21090 Linda Garner 208 Coronet Dr. Linthicum, Md.</b>   |  |   |  |  |  |   |  |

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)  
PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a)

DUE TO, OR AS A CONSEQUENCE OF

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO, OR AS A CONSEQUENCE OF

(c)

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: (a)

MEDICAL CERTIFICATION

|   |  |  |  |  |  |  |  |
|---|--|--|--|--|--|--|--|
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                       |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>  |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19             |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)   |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE  |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |  |  |  |  |  |  |  |
| 22b. SIGNATURE<br><b>Michael F. Plitt MD</b>  |  | DEGREE   |  | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |  | 22c. DATE SIGNED<br><b>1/6/85</b>  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>Michael F. Plitt, MD.</b>   |  |  |  | 22e. ADDRESS<br><b>100 E. Pleasant St. Balto 21202</b>   |  |  |  |

|   |  |                            |  |  |  |  |  |
|---|--|----------------------------|--|--|--|--|--|
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>Burial</b>  |  | 23b. DATE<br><b>1/9/85</b> |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Cedar Hill Cemetery</b> |  | 23d. LOCATION<br>CITY OR TOWN <b>Brooklyn Pk</b> COUNTY <b>A.A.</b> STATE <b>Md.</b> |  |
| 24. FUNERAL DIRECTOR<br>NAME <b>Hubbard Funeral Home, Inc. 4107 Wilkens Ave.</b> ADDRESS <b>21229</b> |  |                            |  | 25a. DATE REC'D. BY REGISTRAR<br><b>JAN 9 1985</b>               |  | 25b. REGISTRAR'S SIGNATURE<br><b>J. Davidson-Randall</b>                             |  |

10/1/62

For deposit to C.

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STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 5 0 1 5 8 7

FOR  
1 - STATE  
REGISTRAR

REG. NO.

|   |  |   |   |   |   |  |  |  |  |
|---|--|---|---|---|---|--|--|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>HENRY L Stokes</b>                         |  |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>1-27-85</b> |   | 2b. HOUR<br><b>10<sup>30</sup> AM</b>                                     |  |  |  |  |
| 3. SEX<br><b>MALE</b>   |  | 4. RACE<br><b>CAUC.</b>   |   | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>10 01 32</b>   |   | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>52</b> YRS.                                  |  | IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS.<br>HOURS MIN. |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>W VA</b>                          |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>US</b>   |   | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> |   | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>BALTO City</b> MD.                      |  |  |  |
| 10. CITY OR TOWN OF DEATH<br><b>BALTO City</b>                                    |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>UNIV OF MD Hospital</b> |   |   |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Painter</b> |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>House</b>                |  |
| 13a. STATE <b>MD</b> 13b. COUNTY <b>BALTO City</b> 13c. CITY OR TOWN <b>BALTO</b> |  |   |   |   |   |  |  |  |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Andrew Stokes</b>                    |  |   |   |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Juanita Vipperman</b> |  |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>No</b> |  |   | 16b. SOCIAL SECURITY NO.<br><b>234-52-1100</b>        |   |   | 17. INFORMANT (sister) ADDRESS<br><b>Edith R. Hizer Same as 13</b>                 |  |  |  |

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)  
PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) **Respiratory Failure**

DUE TO, OR AS A CONSEQUENCE OF

(b) **METASTATIC CARCINOMA of HEAD + NECK**

DUE TO, OR AS A CONSEQUENCE OF

(c)

APPROXIMATE INTERVAL  
BETWEEN ONSET AND DEATH

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)

|  |  |  |  |  |  |   |  |
|--|--|--|--|--|--|---|--|
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                       |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>  |  | 20b. IF YES, WERE FINDINGS USED<br>IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>      |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)   |  |   |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE  |  |   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>Dec 19 84</b> to <b>Jan 27 19 85</b> , that (I) (we) last saw the deceased alive on <b>JAN 27 19 85</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (we) (did) (did not) view the body after death. |  |  |  |  |  |   |  |
| 22b. SIGNATURE<br><b>Robert C Cook</b>   |  |  |  | DEGREE<br>ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> |  | 22c. DATE SIGNED<br><b>1-27-85</b>  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>ROBERT C COOK</b>  |  |  |  | 22e. ADDRESS<br><b>UNH - BAL MD</b>  |  |   |  |

|  |  |                                  |  |   |  |   |  |
|--|--|----------------------------------|--|---|--|---|--|
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>Burial</b>                            |  | 23b. DATE<br><b>Feb. 2, 1985</b> |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Wallace Memorial Cemetery,</b> |  | 23d. LOCATION<br>CITY OR TOWN STATE<br><b>Clintonville Greenbrier Co., W. VA.</b> |  |
| 24. FUNERAL DIRECTOR<br>NAME ADDRESS<br><b>Capitol Funeral Service, Falls Church, VA</b> |  |                                  |  | 25a. DATE REC'D. BY REGISTRAR<br><b>FEB 5 1985</b>                      |  | 25b. REGISTRAR'S SIGNATURE  |  |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.



100

1-24-82

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STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

FOR  
STATE  
REGISTRAR

1. DECEASED NAME  
(TYPE OR PRINT)

FIRST

MIDDLE

LAST

Levy

Stokes

2. SEX

MALE

4. RACE

BLACKS

5. DATE OF BIRTH

11-20-20

6. AGE (IN YEARS)

64 YRS.

IF UNDER 1 YR.

MONTHS DAYS

IF UNDER 24 HRS.

HOURS MIN.

2a. DATE KNOWN OF DEATH

☒ MONTH

DAY

YEAR

19 85

2b. HOUR

2c. DATE PRONOUNCED DEAD

☐ 1

4

19 85

2d. HOUR

3:01 P M

7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)

TEACHES NORTH CAROLINA

7b. CITIZEN OF WHAT COUNTRY?

U.S.

8. MARRIED ☐ NEVER MARRIED ☒

WIDOWED ☐ DIVORCED ☐

9. BALTIMORE CITY OR COUNTY OF DEATH

Baltimore City

10. CITY OR TOWN OF DEATH

Baltimore

11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION

Provident Hospital

12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)

MACHINE OPERATOR

12b. KIND OF BUSINESS OR INDUSTRY

USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE

MD.

13b. COUNTY

Baltimore City

13d. INSIDE CITY LIMITS?

YES ☒ NO ☐

13e. STREET ADDRESS

3700 Liberty Hts Ave

14. FATHER'S NAME

CHANCY

MIDDLE

STOKES

15. MOTHER'S MAIDEN NAME

LOVIT

MIDDLE

STOKES

16a. WAS DECEASED EVER IN U.S. ARMED FORCES?

N/A

(IF YES, GIVE WAR OR DATES)

16b. SOCIAL SECURITY NO.

242-167580

17. INFORMANT

ADDRESS

William Stokes 2200 Mt. Holly

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) Arteriosclerotic Cardiovascular Disease

DUE TO, OR AS A CONSEQUENCE OF

Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last:

(b) DUE TO, OR AS A CONSEQUENCE OF

(c)

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)

Carcinoma of mouth

19a. DATE OF OPERATION

19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?

20. AUTOPSY?

YES ☐ NO ☒

21a. EXTERNAL CAUSE WAS

UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH

21b. TIME OF INJURY

HOUR A.M. MONTH DAY YEAR

P.M. 19

21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)

21d. INJURY OCCURRED

WHILE ☐ NOT WHILE ☐ AT WORK ☐

21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)

21f. LOCATION

CITY OR TOWN

COUNTY

STATE

22a. I certify that I took charge of the remains described above, held on death resulted from Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐ and in my opinion

ACTUAL SIGNATURE

TITLE (SPECIFY)

Acting Chief MEDICAL EXAMINER

DATE SIGNED 1/5/85

EXAMINER'S NAME (TYPE OR PRINT)

Thomas D. Smith, M.D.

ADDRESS 111 Penn Street

Baltimore, MD

23a. BURIAL, CREMATION, REMOVAL (SPECIFY)

BURIAL

23b. DATE

1-9-85

23c. NAME OF CEMETERY OR CREMATORY

STOKES Cemetery

23d. LOCATION

TEACHES NORTH CAROLINA

24. RODNEY T. SYKES

4644

Pimlico Rd.

25a. DATE REC'D. BY REGISTRAR

JAN 7 1985

25b. REGISTRAR'S SIGNATURE

Juha Davidson

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

07/B4  
25M

BP

DHMH - 17  
(VR A15 ME (5))



Items 18-22a 3/5/85 mth  
 FOR 1- STATE F#601  
 REGISTRAR  
 DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

|  |  |                  |   |   |  |   |  |   |   |  |  |  |  |
|--|--|------------------|---|---|--|---|--|---|---|--|--|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>Phyllis (Phillis) R. Stokes   |  |                  | 2a. DATE OF DEATH<br>KNOWN ESTIMATED<br><input checked="" type="checkbox"/> MONTH DAY YEAR<br>1/ 15/ 1985                             |   |  | 2b. HOUR<br>5:38<br>A M   |  |   |   |  |  |  |  |
| 3. SEX<br>Female   |  | 4. RACE<br>Black |   | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>7 15 56               |  | 6. AGE (IN YEARS)<br>(LAST BIRTHDAY)<br>28 YRS.   |  | 7. IF UNDER 1 YR.<br>MONTHS DAYS HOURS MIN.   |   | 2c. DATE PRONOUNCED DEAD<br>1/15/ 1985   |  | 2d. HOUR<br>A M                              |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Maryland  |  |                  | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.A.  |   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  |   | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Baltimore City, MD.   |  |  |  |  |
| 10. CITY OR TOWN OF DEATH<br>Baltimore   |  |                  | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>Union Memorial Hospital |   |  |   |  |   | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) |  |  | 12b. KIND OF BUSINESS OR INDUSTRY            |  |
| 13a. STATE<br>Maryland   |  |                  |   | 13b. COUNTY   |  | 13c. CITY OR TOWN<br>Baltimore  |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |   | 13e. STREET ADDRESS<br>21239<br>1348 Silverthorne Road   |  |  |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>Herman Stokes  |  |                  |   |   |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Julia Fedd   |  |   |   |  |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO, OR UNKNOWN)<br>NO  |  |                  |   | 16b. SOCIAL SECURITY NO.                                    |  | 17. INFORMANT<br>Julia M. Stokes  |  |   |   | ADDRESS<br>1348 Silverthorne Rd.   |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) Spontaneous intracerebral Hemorrhage<br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.<br>(b) DUE TO, OR AS A CONSEQUENCE OF<br>(c)   |  |                  |   |   |  |   |  |   |   |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I   |  |                  |   |   |  |   |  |   |   |  |  |  |  |
| 19a. DATE OF OPERATION   |  |                  |   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?           |  |   |  |   |   | 20. AUTOPSY?<br>HEAD ONLY<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |  |  |
| 21a. EXTERNAL CAUSE WAS<br>UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH   |  |                  |   | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |  |   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)                   |   |  |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  |  |                  |   | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) |  |   |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |   |  |  |  |  |
| 22a. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> . |  |                  |   |   |  |   |  |   |   |  |  |  |  |
| ACTUAL SIGNATURE<br>   |  |                  |   |   |  | TITLE (SPECIFY)<br>M.D. Assistant MEDICAL EXAMINER  |  |   |   |  |  | DATE SIGNED<br>1/16/85                       |  |
| EXAMINER'S NAME<br>(TYPE OR PRINT)<br>Gregory R. Kauffman, M.D.  |  |                  |   |   |  | ADDRESS<br>111 Penn St.   |  |   |   |  |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>BURIAL  |  |                  |   | 23b. DATE<br>1/19/85  |  | 23c. NAME OF CEMETERY OR CREMATORY<br>Cedar Hill Cemetery   |  |   |   | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Anne Arundel Co, Md                                |  |  |  |
| 24. FUNERAL DIRECTOR<br>NAME<br>Wm C March F/H Inc.  |  |                  |   |   |  | ADDRESS<br>1101 E North Avenue  |  |   |   | 25a. DATE REC'D. BY REGISTRAR<br>JAN 17 1985   |  | 25b. REGISTRAR'S SIGNATURE<br>               |  |

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF, MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED (WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL).

REPORT NOTED 3008

CHIEF MANAGER



RECEIVED  
JAN 10 1964

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the death certificate in the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner who shall be present.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH   |  |  |   |   |  |  |  |   |  | 8 5 0 1 5 9 0  |   |  |
|--|--|--|---|---|--|--|--|---|--|--|---|--|
| 1. FOR STATE REGISTRAR   |  |  |   |   | REG. NO.   |  |  |   |  |  |   |  |
| 1. DECEASED NAME (TYPE OR PRINT)<br><b>MARY C. STOOKLEE</b>  |  |  |   |   | 2a. DATE OF DEATH MONTH DAY YEAR<br><b>1-11-85</b>               |  |  |   | 2b. HOUR<br><b>10:20 AM</b>  |  |   |  |
| 3 SEX<br><b>F</b>  |  | 4 RACE<br><b>WHITE</b>   |   | 5 DATE OF BIRTH MONTH DAY YEAR<br><b>1 28 98</b>  |  | 6 AGE (IN YEARS LAST BIRTHDAY)<br><b>86</b>                                      |  |   | 7 UNDER 1 YEAR<br>MONTHS DAYS HOURS MIN.   |  |   |  |
| 7a BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>W. VIRGINIA</b>   |  | 7b CITIZEN OF WHAT COUNTRY?<br><b>USA</b>  |   | 8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9 BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore City</b> MD.                 |  |   |  |  |   |  |
| 10 CITY OR TOWN OF DEATH<br><b>BALTIMORE</b>   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>MASON FLOW FACILITY</b> |   |   |  | 12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Homemaker</b> |  |   | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>Home</b>   |  |   |  |
| 13a. STATE<br><b>MA</b>  |  |  |   |   | 13b. COUNTY<br><b>BALTx</b>                                      |  | 13c. CITY OR TOWN<br><b>Dundalk</b>  |   | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                            |  | 13e. STREET ADDRESS<br><b>4062 St Monica Dr</b> |  |
| 14 FATHER'S NAME FIRST MIDDLE LAST<br><b>Joseph Lynch</b>  |  |  |   |   | 15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST<br><b>SUSAN Curtis</b> |  |  |   |  |  |   |  |
| 16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)<br><b>No</b>  |  |  |   |   | 16b SOCIAL SECURITY NO<br><b>224-66-2566</b>                     |  | 17 INFORMANT ADDRESS<br><b>Katherine K. Musarra same as 13e</b>                      |   |  |  |   |  |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c):<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>PROBABLE SEPSIS</b><br>DUE TO, OR AS A CONSEQUENCE OF (b) <b>URINARY TRACT INFECTION OR PNEUMONIA</b><br>DUE TO, OR AS A CONSEQUENCE OF (c) <b>—</b>   |  |  |   |   |  |  |  |   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>7d</b><br><b>7d</b> |   |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a<br><b>ALZHEIMER'S DISEASE</b>   |  |  |   |   |  |  |  |   |  |  |   |  |
| 19a. DATE OF OPERATION<br><b>1/1</b>   |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED<br><b>1/1</b>      |   |  |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |   | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |   |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |  |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR<br><b>19</b>           |   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18: PART I OR PART 2)   |  |   |  |  |   |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK   |  |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) |   |  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE                                   |  |   |  |  |   |  |
| 22a. I certify that (1) this hospital attended the deceased from <b>4-5-84</b> , 19 <b>—</b> , to <b>1-11</b> , 19 <b>85</b> , that (1) <input checked="" type="radio"/> I saw the deceased alive on <b>1-11-85</b> , 19 <b>—</b> , and that in (my) <input checked="" type="radio"/> opinion death occurred on the date and hour and from the causes stated above. (2) <input type="radio"/> I did not view the body after death. |  |  |   |   |  |  |  |   |  |  |   |  |
| 22b. SIGNATURE<br><b>AJ Lucas</b>  |  |  |   |   | DEGREE<br><b>MD</b>  |  |  |   |  | 22c. DATE SIGNED<br><b>1-12-85</b>                                     |   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>AJ Lucas</b>   |  |  |   |   | 22e. ADDRESS<br><b>5200 EASTERN AVE, BALTO MD</b>                |  |  |   |  |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL<br><b>Burial</b>   |  |  | 23b. DATE<br><b>1-16-85</b>   |   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Bridgeport Cem.</b>     |  |  | 23d. LOCATION CITY OR TOWN COUNTY STATE<br><b>Bridgeport Harrison W.Va.</b> |  |  |   |  |
| 24. FUNERAL DIRECTOR (NAME ADDRESS)<br><b>Duda-Ruck inc. 7922 Wise Ave Balto. Md</b>   |  |  |   |   |  | 25a. DATE REC'D. BY REGISTRAR<br><b>JAN 14 1985</b>                              |  | 25b. REGISTRAR'S SIGNATURE<br><b>Julia Davidson-Randall</b>                 |  |  |   |  |





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8501591

|  |   |   |   |
|--|---|---|---|
| 1- FOR<br>STATE<br>REGISTRAR   |   | REG. NO.  |   |
| 1 DECEASED NAME<br>(TYPE OR PRINT)   |   | 2a DATE OF DEATH  |   |
| ALICE C. STOUT   |   | 1/26/85   |   |
| 3 SEX  | 4 RACE  | 5. DATE OF BIRTH  | 6. AGE (IN YEARS LAST BIRTHDAY)                               |
| FEMALE   | WHITE   | 055 - 12 - 1892   | 92 YRS.   |
| 7a BIRTHPLACE (STATE OR FOREIGN COUNTRY)   | 7b CITIZEN OF WHAT COUNTRY?   | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 9. BALTIMORE CITY OR COUNTY OF DEATH                          |
| MARYLAND   | U.S.A.  |   | BALTIMORE CITY MD.  |
| 10 CITY OR TOWN OF DEATH   | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | 12a USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)   | 12b KIND OF BUSINESS OR INDUSTRY                              |
| BALTIMORE  | ST. AGNES HOSPITAL  | HOMEMAKER   | ---   |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)  |   | 13d. INSIDE CITY LIMITS?  |   |
| 13a. STATE   | 13b. COUNTY   | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |   |
| MARYLAND   | HOWARD  | 13e STREET ADDRESS / ZIP CODE   |   |
| 14 FATHER'S NAME<br>FIRST MIDDLE LAST  | 15 MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST  | 5984 SETTER DRIVE, 21227  |   |
| JOHN LEFFERT   | MARY SIPES  |   |   |
| 16a WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)  | 16b SOCIAL SECURITY NO.   | 17 INFORMANT  | ADDRESS   |
| NO   | 216-10-6740   | ETHEL L. HOPP   | 5984 SETTER DRIVE 21227                                       |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Cerebrovascular Accident</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) _____<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last }<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____<br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><u>21 days</u> |   |   |   |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)  |   |   |   |
| 19a DATE OF OPERATION  | 19b CONDITION FOR WHICH OPERATION WAS PERFORMED   | 20a AUTOPSY?  | 20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? |
|  |   | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   | YES <input type="checkbox"/> NO <input type="checkbox"/>      |
| 21a ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  | 21b TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19   | 21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)  |   |
| 21d INJURY OCCURRED<br>WHERE <input type="checkbox"/> NOT WHERE <input type="checkbox"/><br>AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>  | 21e PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                                     | 21f LOCATION<br>STREET CITY OR TOWN COUNTY STATE  |   |
| 22a I certify that (I) (this hospital) attended the deceased from <u>1/26</u> , 19 <u>85</u> , to <u>1/26</u> , 19 <u>85</u> , that (I) (we) last saw the deceased alive on <u>1/26</u> , 19 <u>85</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.  |   |   |   |
| 22b SIGNATURE<br><u>John P Lavery</u>  | DEGREE<br>MD  | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>                  | 22c DATE SIGNED<br><u>1/26/85</u>                             |
| 22d PHYSICIAN'S NAME (TYPE OR PRINT)<br><u>JOHN P LAVERY</u>   | 22e ADDRESS<br><u>St. Agnes Hospital Baltimore MD</u>   |   |   |
| 23a BURIAL, CREMATION, REMOVAL<br>(SPECIFY)  | 23b DATE  | 23c NAME OF CEMETERY OR CREMATORY   | 23d LOCATION<br>CITY OR TOWN COUNTY STATE                     |
| BURIAL   | 01-28-85  | LORRAINE PARK   | WOODLAWN BALTIMORE MARYLAND                                   |
| 24 FUNERAL DIRECTOR<br>NAME  | 24b ADDRESS   | 25a DATE REC'D. BY REGISTRAR  | 25b REGISTRAR'S SIGNATURE                                     |
| HUBBARD FUNERAL HOME, INC.   | 4107 WILKENS AVE.   | JAN 28 1985   | <u>Julia Davidson-Randall</u>                                 |

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U.S. AIR FORCE



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FROM: SAC, NEW YORK

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DATE: 1/2/61

RE: [Illegible]

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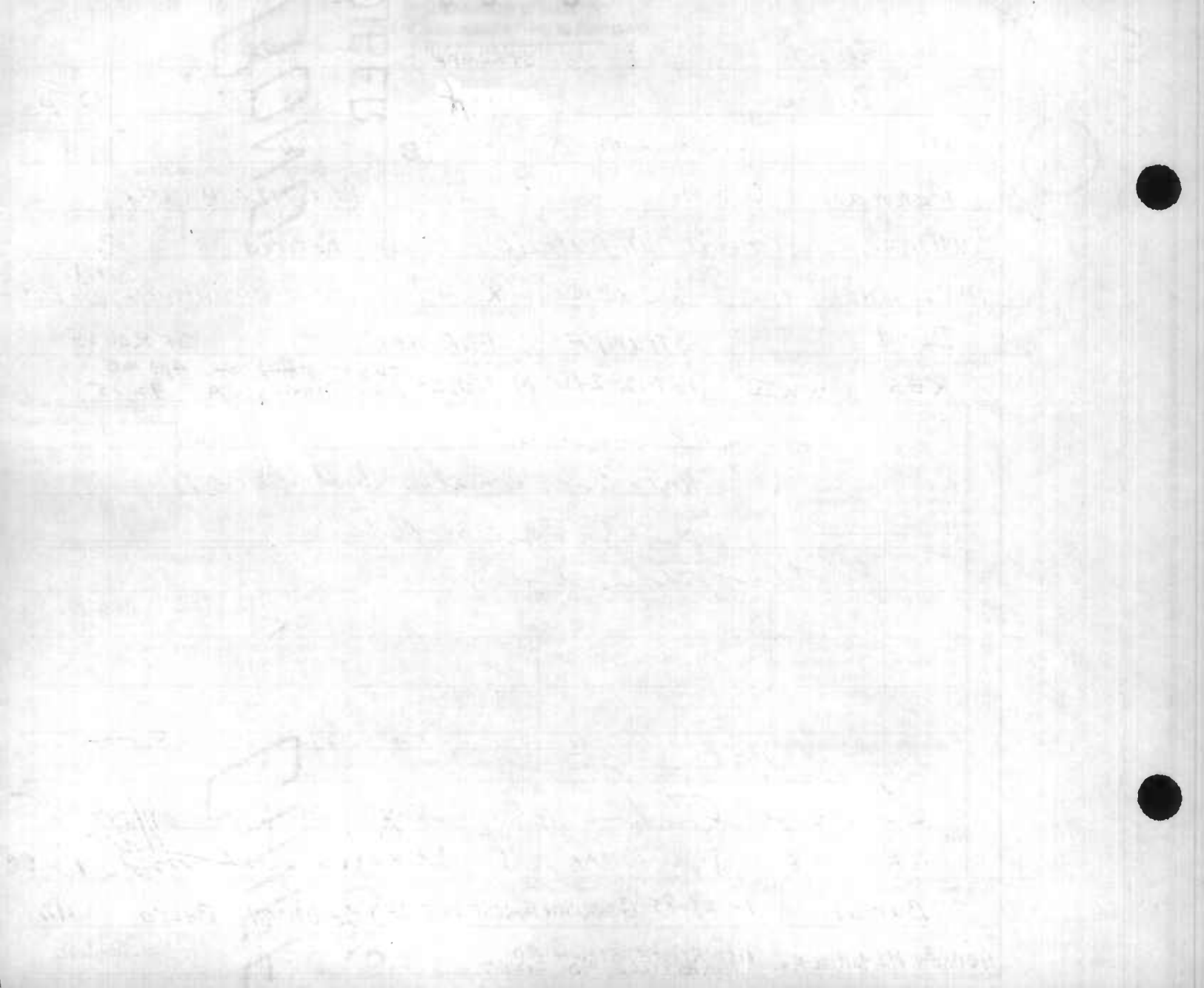
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STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

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FOR  
STATE  
REGISTRAR

REG. NO.

|  |  |  |  |   |  |   |  |
|--|--|--|--|---|--|---|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>FIRST MIDDLE LAST<br>LAMONT L. STUART   |  |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br>1 18 85 |   |  | 2b. HOUR<br>10 AM   |  |
| 3. SEX<br>MALE   |  | 4. RACE<br>BLACK   |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>8 30 42   |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br>42 YRS.  |  |
| 7a. BIRTHPLACE<br>(STATE OR FOREIGN COUNTRY)<br>N.C.   |  | 7b. CITIZEN OF WHAT COUNTRY?<br>USA  |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Baltimore City MD.  |  |
| 10. CITY OR TOWN OF DEATH<br>Baltimore   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>Francis Scott Key |  |   |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)  |  |
| 13a. STATE<br>BALTIMORE  |  | 13b. CITY OR TOWN<br>BALT.   |  | 13c. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>   |  | 13d. STREET ADDRESS / ZIP CODE<br>2728 Ashland Ave. 21205   |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>- - -  |  |  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Jannie Stuart  |  |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br>NO   |  | 16b. SOCIAL SECURITY NO.<br>214-38-5450  |  | 17. INFORMANT<br>ADDRESS<br>Jannie Garland 2734 Ashland Ave.  |  |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>RESPIRATORY ARREST</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <u>MIDBRAINSTEM INFARCT</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <u>PNEUMOCOCCAL MENINGITIS.</u><br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br>4 WKS. |  |  |  |   |  |   |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: (a)   |  |  |  |   |  |   |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>   |  | 20b. IF YES, WERE FINDINGS USED<br>IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)   |  |   |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.  |  |  |  |   |  |   |  |
| 22b. SIGNATURE<br>Gerard Gallucci  |  |  |  | DEGREE<br>MD  |  | 22c. DATE SIGNED<br>1/18/85   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>GERARD GALLUCCI   |  |  |  | 22e. ADDRESS<br>4940 Eastern Ave. Balt. MD.   |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br>Cremation  |  | 23b. DATE<br>1/21/85   |  | 23c. NAME OF CEMETERY OR CREMATORY<br>Westview Mem. pk.   |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Baltimore Co. MD  |  |
| 24. FUNERAL DIRECTOR<br>NAME<br>Wm. C. March F/H   |  |  |  | ADDRESS<br>1101 E. North Ave.   |  | 25a. DATE REC'D. BY REGISTRAR<br>JAN 21 1985  |  |
|  |  |  |  | 25b. REGISTRAR'S SIGNATURE<br>G. Davidson   |  |   |  |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PA 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITH THE VITAL RECORDS AFTER DEATH. WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>MEDICAL EXAMINER'S CERTIFICATE OF DEATH   |  |  |  |  |  |  |  |  |  | REG. NO. 01594   |  |
|---|--|--|--|--|--|--|--|--|--|--|--|
| 1- STATE REGISTRAR  |  |  |  |  |  |  |  |  |  |  |  |
| 1 DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST<br>LARRY RAY STURGILL   |  |  |  |  |  |  |  |  |  | 2a. DATE KNOWN OF ESTI- MATED <input checked="" type="checkbox"/> 1-12-85 <sup>9</sup> |  |
| 3 SEX Male 4 RACE White 5 DATE OF BIRTH MONTH DAY YEAR Sept. 3, 1958 6 AGE (IN YEARS LAST BIRTHDAY) 26 7a. CITIZEN OF WHAT COUNTRY? USA 8 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>   |  |  |  |  |  |  |  |  |  | 2b. HOUR M 2:25A   |  |
| 7b. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland 7c. DATE PRONOUNCED DEAD 1-12-85 <sup>9</sup>  |  |  |  |  |  |  |  |  |  | 2d. HOUR M 2:25A   |  |
| 9 BALTIMORE CITY OR COUNTY OF DEATH Baltimore City  |  |  |  |  |  |  |  |  |  |  |  |
| 10 CITY OR TOWN OF DEATH Baltimore 11 NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) University Hospital STU   |  |  |  |  |  |  |  |  |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Expeditor                |  |
| 12b. KIND OF BUSINESS OR INDUSTRY Wire Co.  |  |  |  |  |  |  |  |  |  |  |  |
| 13a. USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13b. STATE PA 13c. COUNTY York 13d. CITY OR TOWN Shrewsbury 13e. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>  |  |  |  |  |  |  |  |  |  | 13f. STREET ADDRESS 205 S. Church St. 17361  |  |
| 14 FATHER'S NAME FIRST MIDDLE LAST Jessie L. Sturgill   |  |  |  |  |  |  |  |  |  | 15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Hilma M. Mullins                             |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) Yes 16b. SOCIAL SECURITY NO. 1975-1976 218-72-0251   |  |  |  |  |  |  |  |  |  | 17 INFORMANT ADDRESS Mr. Jessie L. Sturgill, 205 S. Church St., Shrewsbury, PA 17361   |  |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1 DEATH WAS CAUSED BY: 8/20 IMMEDIATE CAUSE (a) Multiple injuries<br>Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost.<br>(b) DUE TO, OR AS A CONSEQUENCE OF<br>(c) DUE TO, OR AS A CONSEQUENCE OF<br>PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) |  |  |  |  |  |  |  |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH   |  |
| 19a. DATE OF OPERATION  |  |  |  |  |  |  |  |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?                                      |  |
| 20 AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>   |  |  |  |  |  |  |  |  |  |  |  |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH  |  |  |  |  |  |  |  |  |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR 1AM 1-12-85 <sup>9</sup>                  |  |
| 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) Driver of auto/auto head-on collision   |  |  |  |  |  |  |  |  |  |  |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK  |  |  |  |  |  |  |  |  |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) street                     |  |
| 21f. LOCATION York Rd. S. of Westbury Rd. Balto., Md. STATE   |  |  |  |  |  |  |  |  |  |  |  |
| 22a. I certify that I took charge of the remains described above, held on death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion                                |  |  |  |  |  |  |  |  |  |  |  |
| ACTUAL SIGNATURE <i>GR</i> TITLE (SPECIFY) M.D. Assistant MEDICAL EXAMINER  |  |  |  |  |  |  |  |  |  | DATE SIGNED 1-12-85  |  |
| EXAMINER'S NAME (TYPE OR PRINT) Gregory R. Kauffman, M.D. ADDRESS 111 Penn Street   |  |  |  |  |  |  |  |  |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial  |  |  |  |  |  |  |  |  |  | 23b. DATE Jan. 14, 1985  |  |
| 23c. NAME OF CEMETERY OR CREMATORY Dulaney Valley Memorial Gardens  |  |  |  |  |  |  |  |  |  | 23d. LOCATION CITY OR TOWN Timonium, COUNTY Balto., STATE MD                           |  |
| 24 FUNERAL DIRECTOR NAME J. J. Hartenstein, New Freedom, PA 17349   |  |  |  |  |  |  |  |  |  | 25 REGISTRAR'S SIGNATURE <i>John Davidson</i>  |  |



et al.

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

85 01595

1- FOR  
STATE  
REGISTRAR

REG. NO.

|   |  |  |   |  |  |  |  |  |
|---|--|--|---|--|--|--|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>Pauline Anna Suehle</b>  |  |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>31 23 85</b>  |  |  | 2b. HOUR<br><b>230</b>   |  |  |
| 3. SEX<br><b>Female</b>   |  |  | 4. RACE<br><b>White</b>   |  |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>05 19 94</b>  |  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Baltimore, Md.</b>  |  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.</b>   |  |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>90</b>   |  |  |
| 10. CITY OR TOWN OF DEATH<br><b>Baltimore City</b>  |  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>John L. Beaton Medical Center</b>   |  |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore City</b>  |  |  |
| 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Telephone Operator</b>   |  |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>—</b>   |  |  | 13a. STREET ADDRESS / ZIP CODE<br><b>9604 Hickory Hurst Dr. 21236</b>  |  |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>John Unknown</b>   |  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Anna Svala</b>  |  |  | 16. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)<br><b>unknown</b>                                  |  |  |
| 17. INFORMANT<br>ADDRESS<br><b>Charles Suehle (Son) 9604 Hickory Hurst Dr.</b>  |  |  | 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Septis.</b><br>DUE TO, OR AS A CONSEQUENCE OF (b) <b>Multiple infected decubiti</b><br>DUE TO, OR AS A CONSEQUENCE OF (c) <b>Parkinson's Disease</b><br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>weeks</b><br><b>months</b><br><b>years</b> |  |  | PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)<br><b>CBS</b> |  |  |
| 19a. DATE OF OPERATION  |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>11/20 19 84</b>   |  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)   |  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>  |  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>1/23 19 85</b> to <b>1/23 19 85</b> , that (we) last saw the deceased alive on <b>1/23 19 85</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (we) (did) (did not) view the body after death. |  |  |   |  |  |  |  |  |
| 22b. SIGNATURE<br><b>J.P. Glodue, MD</b>  |  |  | DEGREE<br><b>MD</b>   |  |  | 22c. DATE SIGNED<br><b>1/23/85</b>   |  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)   |  |  | 22e. ADDRESS  |  |  |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>Removal</b>  |  |  | 23b. DATE<br><b>1/23/85</b>   |  |  | 23c. NAME OF CEMETERY OR CREMATORY   |  |  |
| 23d. LOCATION<br>CITY OR TOWN COUNTY STATE  |  |  | 23e. DATE REC'D. BY REGISTRAR   |  |  | 23f. REGISTRAR'S SIGNATURE<br><b>Jana Davidson-Ridell</b>  |  |  |
| 24. FUNERAL DIRECTOR<br>NAME ADDRESS<br><b>State of Md. Anatomy Board - 655 W. Baltimore St.</b>  |  |  |   |  |  |  |  |  |

BP

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.



RECEIVED  
JAN 10 1900

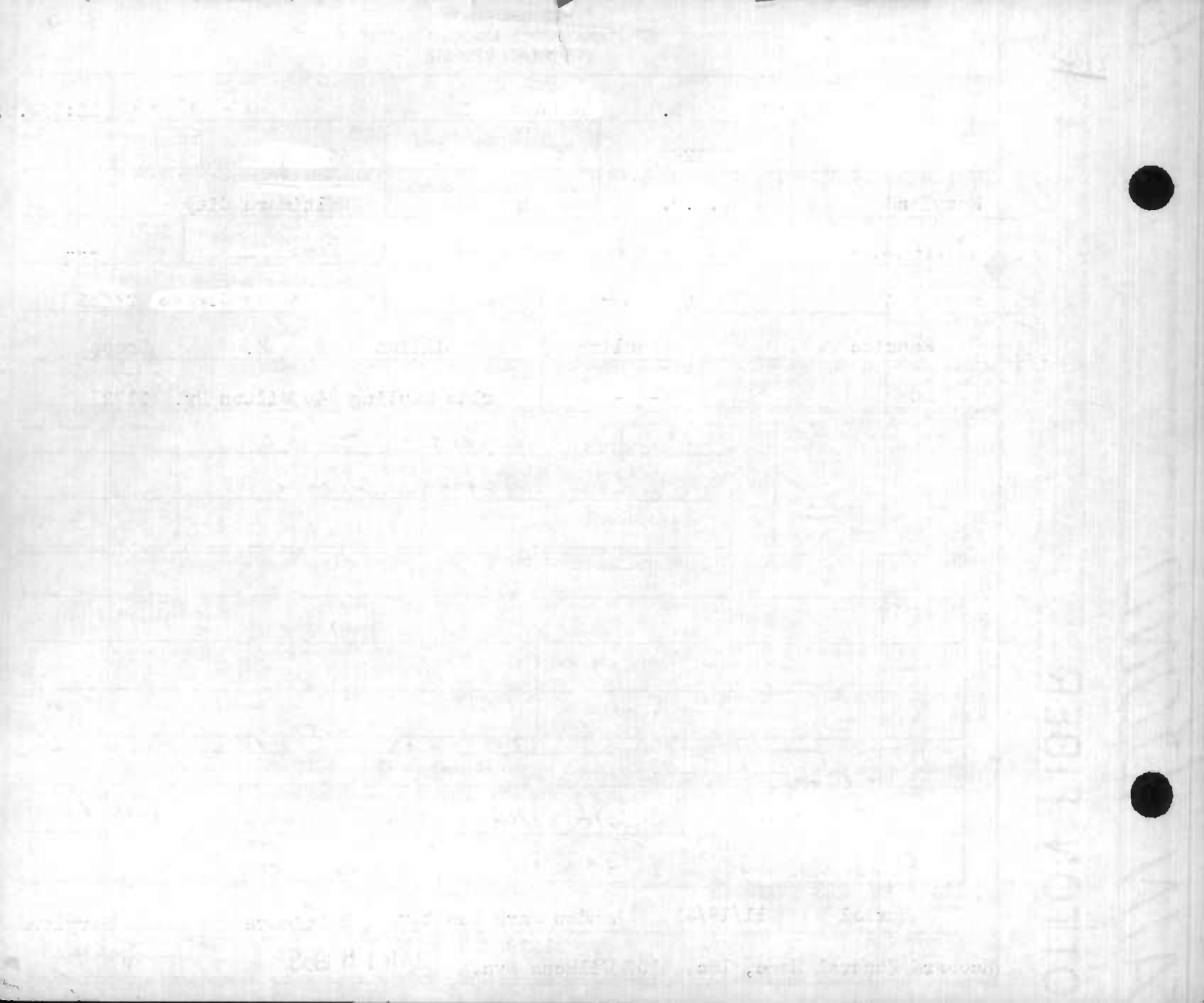
*[Faint, mostly illegible handwritten text, possibly bleed-through from the reverse side of the page. Some words like "multiple" and "specimens" are faintly visible.]*

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 1, 2, and 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH   |  |   |  |   |   |   |  |  |  | REG. NO. |  |
|--|--|---|--|---|---|---|--|--|--|----------|--|
| 1. FOR STATE REGISTRAR   |  |   |  |   |   |   |  |  |  |          |  |
| 1. DECEASED NAME<br>(TYPE OR PRINT) FIRST MIDDLE LAST<br><b>ELIZABETH L. SULLIVAN</b>  |  |   |  |   | 2a. DATE OF DEATH MONTH DAY YEAR<br><b>1-15-85</b>                    |   |  | 2b. HOUR<br><b>12:55 P.M.</b>  |  |          |  |
| 3. SEX<br><b>FEMALE</b>  |  | 4. RACE<br><b>WHITE</b>   |  | 5. DATE OF BIRTH MONTH DAY YEAR<br><b>5 12 15</b>   |   | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>69</b> YRS  |  | IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS<br>HOURS MIN.  |  |          |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Maryland</b>   |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore City</b> MD.                               |  |  |  |          |  |
| 10. CITY OR TOWN OF DEATH<br><b>Baltimore</b>  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>University Hospital</b> |  |   |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Homemaker</b>            |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>---</b>  |  |          |  |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)  |  |   |  |   |   |   |  |  |  |          |  |
| 13a. STATE<br><b>Maryland</b>  |  | 13b. COUNTY   |  | 13c. CITY OR TOWN<br><b>Baltimore</b>   |   | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 13e. STREET ADDRESS / ZIP CODE<br><b>2003 Ramsey Street 21223</b>  |  |          |  |
| 14. FATHER'S NAME FIRST MIDDLE LAST<br><b>Maurice Reuling</b>  |  |   |  |   | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST<br><b>Lillian M. Knopp</b> |   |  |  |  |          |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>NO</b>  |  | 16b. SOCIAL SECURITY NO.<br><b>214-64-5667</b>  |  | 17. INFORMANT ADDRESS<br><b>Charles Reuling 940 Wilton Dr. 21227</b>  |   |   |  |  |  |          |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Cardiac arrest</b><br>DUE TO, OR AS A CONSEQUENCE OF (b) <b>Coronary Artery Disease</b><br>DUE TO, OR AS A CONSEQUENCE OF (c)<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. |  |   |  |   |   |   |  |  |  |          |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)   |  |   |  |   |   |   |  |  |  |          |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  |   |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>                       |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |          |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)  |   |   |  |  |  |          |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |   |   |  |  |  |          |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>12-19, 1985</b> , to <b>1-15, 1985</b> , that (I) (we) lost<br>saw the deceased alive on <b>1-15, 1985</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated<br>above, (I) (we) (we do not) view the body after death.                         |  |   |  |   |   |   |  |  |  |          |  |
| 22b. SIGNATURE<br><b>Fredrick J. Sutton</b>  |  | DEGREE<br><b>MD</b>   |  | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>                  |   |   |  | 22c. DATE SIGNED<br><b>1-15-85</b>   |  |          |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>Fredrick J. Sutton</b>   |  | 22e. ADDRESS<br><b>University Hospital Baltimore MD</b>   |  |   |   |   |  |  |  |          |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY) <b>Burial</b>   |  | 23b. DATE<br><b>11/19/85</b>  |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Loudon Park Cemetery</b>   |   | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Baltimore Maryland</b>                         |  |  |  |          |  |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>Hubbard Funeral Home, Inc.</b>  |  | ADDRESS<br><b>4107 Wilkens Ave.</b>   |  | 25a. DATE REC'D. BY REGISTRAR<br><b>JAN 18 1985</b>   |   | 25b. REGISTRAR'S SIGNATURE<br><b>Davidson-Randall</b>   |  |  |  |          |  |



STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

85 01597

FOR  
STATE  
REGISTRAR

REG. NO.

|  |  |   |   |   |  |   |
|--|--|---|---|---|--|---|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br><b>George G. Summers</b>  |  |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>January 19, 1985</b>                                  |   | 2b. HOUR<br>M<br><b>AM</b>   |   |
| 3. SEX<br><b>Male</b>  | 4. RACE<br><b>Black</b>  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>3 1 08</b>   |   | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>76</b> YRS  | IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS<br>HOURS MIN.  |   |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Maryland</b>   | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore City,</b> MD.  |  |   |
| 10. CITY OR TOWN OF DEATH<br><b>Baltimore</b>  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>2300 Chelsea Terrace</b> |   |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)  |  | 12b. KIND OF BUSINESS OR INDUSTRY                                 |
| 13a. STATE<br><b>Maryland</b>  | 13b. COUNTY  | 13c. CITY OR TOWN<br><b>Baltimore</b>   | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | 13e. STREET ADDRESS / ZIP CODE<br><b>2nd Floor<br/>2300 Chelsea Terrace 21216</b>   |  |   |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>- - -</b>   |  |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Lillian</b>                                 |   |  |   |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>NO</b>  |  | 16b. SOCIAL SECURITY NO.<br><b>217-01-5412</b>  |   | 17. INFORMANT<br>ADDRESS<br><b>2nd Floor<br/>Ella F. Summers 2300 Chelsea Terrace</b>   |  |   |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>cardio-respiratory failure</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(b) <b>Atherosclerotic heart disease</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <b>vascular insufficiency, Diabetes Mellitus</b> |  |   |   |   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH                      |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: a<br><b>50% foot amputation</b>   |  |   |   |   |  |   |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |   |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>   |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |  |   |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |   |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>12/24</b> , 19 <b>81</b> , to <b>1/12</b> , 19 <b>85</b> , that (I) (we) last saw the deceased alive on <b>1/12</b> , 19 <b>85</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.  |  |   |   |   |  |   |
| 22b. SIGNATURE<br><b>B. P. Thada</b>   |  |   |   | DEGREE<br>ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |  | 22c. DATE SIGNED  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>B. P. THADA</b>  |  |   |   | 22e. ADDRESS<br><b>5356 Reisterstown Rd</b>   |  |   |
| 23a. BURIAL, CREMATION, REMOVAL<br>(TYPE OR PRINT)<br><b>BURIAL</b>  |  | 23b. DATE<br><b>1/24/85</b>   |   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Arbutus Mem. Pk.</b>   |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Arbutus, Md.</b> |
| 24. FUNERAL DIRECTOR<br>NAME ADDRESS<br><b>Wm C March F/H Inc. 1101 E North Avenue</b>   |  |   |   | 25a. DATE REC'D. BY REGISTRAR<br><b>JAN 22 1985</b>   |  |   |
| 25b. REGISTRAR'S SIGNATURE<br><b>Davidson-Randall</b>  |  |   |   |   |  |   |

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MEDICAL CERTIFICATION

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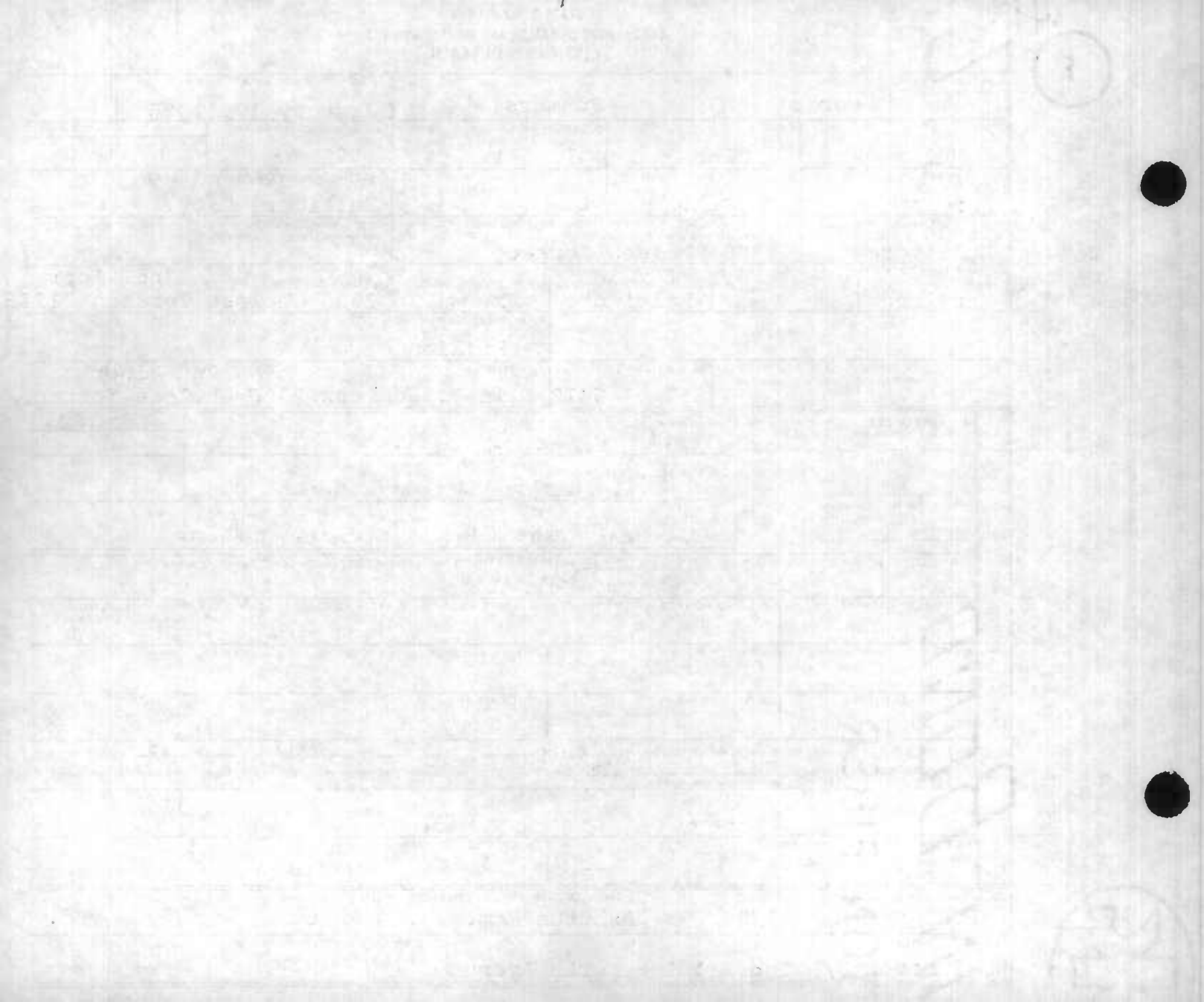
1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 3 and 4 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked as item 18 shows any injury, or other traumatic event, the medical examiner must be notified for ane.

BP





STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1- FOR  
STATE  
REGISTRAR

|   |  |  |   |  |  |  |  |
|---|--|--|---|--|--|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br><i>Charles Swales</i>  |  |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><i>1 24 85</i> |  |  | 2b. HOUR<br><i>8:00 P.</i>   |  |
| 3. SEX<br><i>Male</i>   |  | 4. RACE<br><i>B</i>  |   | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><i>12 28 86</i>  |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><i>98</i>   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><i>Maryland</i>  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><i>USA</i>   |   | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><i>Baltimore City</i>  |  |
| 10. CITY OR TOWN OF DEATH<br><i>BALTO.</i>  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><i>Grenada Nursing Home</i> |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><i>Waiter</i>  |  | 12b. KIND OF BUSINESS OR INDUSTRY  |  |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>STATE<br><i>Maryland</i>  |  | 13b. COUNTY<br><i>Baltimore</i>  |   | 13c. CITY OR TOWN<br><i>Baltimore</i>  |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                            |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><i>GEORGE SWALES</i>  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><i>MARY E. COLE</i>   |   | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><i>NO</i>  |  |  |  |
| 16b. SOCIAL SECURITY NO.<br><i>217-07-638</i>   |  | 17. INFORMANT<br>ADDRESS<br><i>MRS. Elizabeth Somerville Rt 2 Box 159</i>  |   |  |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <i>Chronic obstructive lung disease</i><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <i>Carcinoma of prostate</i><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. |  |  |   |  |  |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) _____   |  |  |   |  |  |  |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19 <i>84</i>   |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)   |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE  |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <i>12/18/84</i> to <i>1/24/85</i> , that (I) (we) lost saw the deceased alive on <i>1/24/85</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (Leave blank if did not see the body after death.)  |  |  |   |  |  |  |  |
| 22b. SIGNATURE<br><i>[Signature]</i>  |  | DEGREE<br><i>MD</i>  |   | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>               |  | 22c. DATE SIGNED<br><i>1/25/85</i>   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)   |  | 22e. ADDRESS   |   |  |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><i>BURIAL</i>  |  | 23b. DATE<br><i>1/28/85</i>  |   | 23c. NAME OF CEMETERY OR CREMATORY<br><i>Mt. Auburn</i>  |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><i>BALTO. MD</i>   |  |
| 24. FUNERAL DIRECTOR<br>NAME<br><i>CHRISTIAN HARRIS</i><br>ADDRESS<br><i>1701 McCulloh St.</i><br>FURNAL HOME   |  |  |   | 25a. DATE REC'D. BY REGISTRAR<br><i>JAN 28 1985</i>  |  |  |  |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 2 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the health officer with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical professional should indicate the nature of the event.

NOV 19 1964



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NOV 19 1964

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 5 0 1 5 9 9

|   |   |  |   |                                      |  |
|---|---|--|---|--------------------------------------|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)   |   | 2a. DATE OF DEATH  |   | 2b. HOUR                             |  |
| JEROME SWARTZ   |   | JANUARY 17, 1985   |   | 12:37AM                              |  |
| 3. SEX  | 4. RACE   | 5. DATE OF BIRTH   | 6. AGE  | 7. BALTIMORE CITY OR COUNTY OF DEATH |  |
| MALE  | WHITE   | DECEMBER 25, 1905  | 79 YRS.   | BALTIMORE CITY MD.                   |  |
| 7a. BIRTHPLACE  | 7b. CITIZEN OF WHAT COUNTRY?                            | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 9. BALTIMORE CITY OR COUNTY OF DEATH                                |                                      |  |
| MARYLAND  | U.S.A.  |  | BALTIMORE CITY MD.  |                                      |  |
| 10. CITY OR TOWN OF DEATH   | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION | 12a. USUAL OCCUPATION  | 12b. KIND OF BUSINESS OR INDUSTRY                                   |                                      |  |
| BALTIMORE   | JOHNS HOPKINS HOSPITAL                                  | MANUFACTURER   | CLOTHING  |                                      |  |
| 13a. STATE  | 13b. COUNTY   | 13c. CITY OR TOWN  | 13d. INSIDE CITY LIMITS?  | 13e. STREET ADDRESS / ZIP CODE       |  |
| MARYLAND  |   | BALTIMORE  | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | 2703 QUEEN ANNE RD. 21216            |  |
| 14. FATHER'S NAME   | 15. MOTHER'S MAIDEN NAME                                | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?   |   |                                      |  |
| TOBIAS I.   | ANNA UNKNOWN  | YES <input type="checkbox"/> NO <input type="checkbox"/> (IF YES, GIVE WAR OR DATES)   |   |                                      |  |
| 16b. SOCIAL SECURITY NO.  | 17. INFORMANT   | ADDRESS  |   |                                      |  |
| 219-14-0062   | MR ROBERT GOLDMAN                                       | 300 E. LOMBARD ST. 21202   |   |                                      |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY:   |   |  |   |                                      | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| IMMEDIATE CAUSE (a) CARDIOPULMONARY ARREST  |   |  |   |                                      | 10-10 MIN.                                   |
| DUE TO, OR AS A CONSEQUENCE OF (b) PULMONARY HEMORRHAGE   |   |  |   |                                      | 6 hours                                      |
| DUE TO, OR AS A CONSEQUENCE OF (c) ACUTE LEUKEMIA   |   |  |   |                                      | 10 days                                      |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)   |   |  |   |                                      |  |
| 19a. DATE OF OPERATION  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED        | 20a. AUTOPSY?  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?      |                                      |  |
|   |   | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |                                      |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  | 21b. TIME OF INJURY                                     | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)   |   |                                      |  |
|   | HOUR A.M. MONTH DAY YEAR P.M. 19                        |  |   |                                      |  |
| 21d. INJURY OCCURRED  | 21e. PLACE OF INJURY                                    | 21f. LOCATION  |   |                                      |  |
| WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK  | (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)          | CITY OR TOWN COUNTY STATE  |   |                                      |  |
| 22a. I certify that (I) (this hospital) attended the deceased from 1/17, 1985, to 1/17, 1985, that (I) (we) last saw the deceased alive on 1/17, 1985, and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. |   |  |   |                                      |  |
| 22b. SIGNATURE  | DEGREE  |  |   | 22c. DATE SIGNED                     |  |
| G.M. GACIOCH  |   |  |   | 1/17/85                              |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)   | 22e. ADDRESS  |  |   |                                      |  |
| G.M. GACIOCH  | JOHNS HOPKINS HOSPITAL                                  |  |   |                                      |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)   | 23b. DATE   | 23c. NAME OF CEMETERY OR CREMATORY   | 23d. LOCATION   | 23e. DATE REC'D BY REGISTRAR         |  |
| CREMATION   | 1/18/85   | WESTVIEW MEMORIAL PARK   | BALTIMORE   | JAN 24 1985                          |  |
| 24. FUNERAL DIRECTOR  | 25. REGISTRAR'S SIGNATURE                               |  |   |                                      |  |
| SOL LEVINSON & BROS., INC.  | Jana Davidson-Randall                                   |  |   |                                      |  |
| 6010 REISTERSTOWN RD. BALTIMORE MARYLAND 21215  |   |  |   |                                      |  |

MEDICAL CERTIFICATION

35

22

1

TO HOSPITAL OR VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial transit permit. Then please remove completed pages 1 and 2 from the file and retain them in 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORT NOTE: If item 21 is marked as item 18, show any injury or other traumatic event, the medical history, and any other pertinent information.

BP

Handwritten mark resembling a stylized 'D' or 'O' with a horizontal line through it.

COPIES OF THE REPORT OF THE COMMISSIONER OF THE GENERAL LAND OFFICE, DEPARTMENT OF THE INTERIOR, FOR THE YEAR 1884.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.  
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

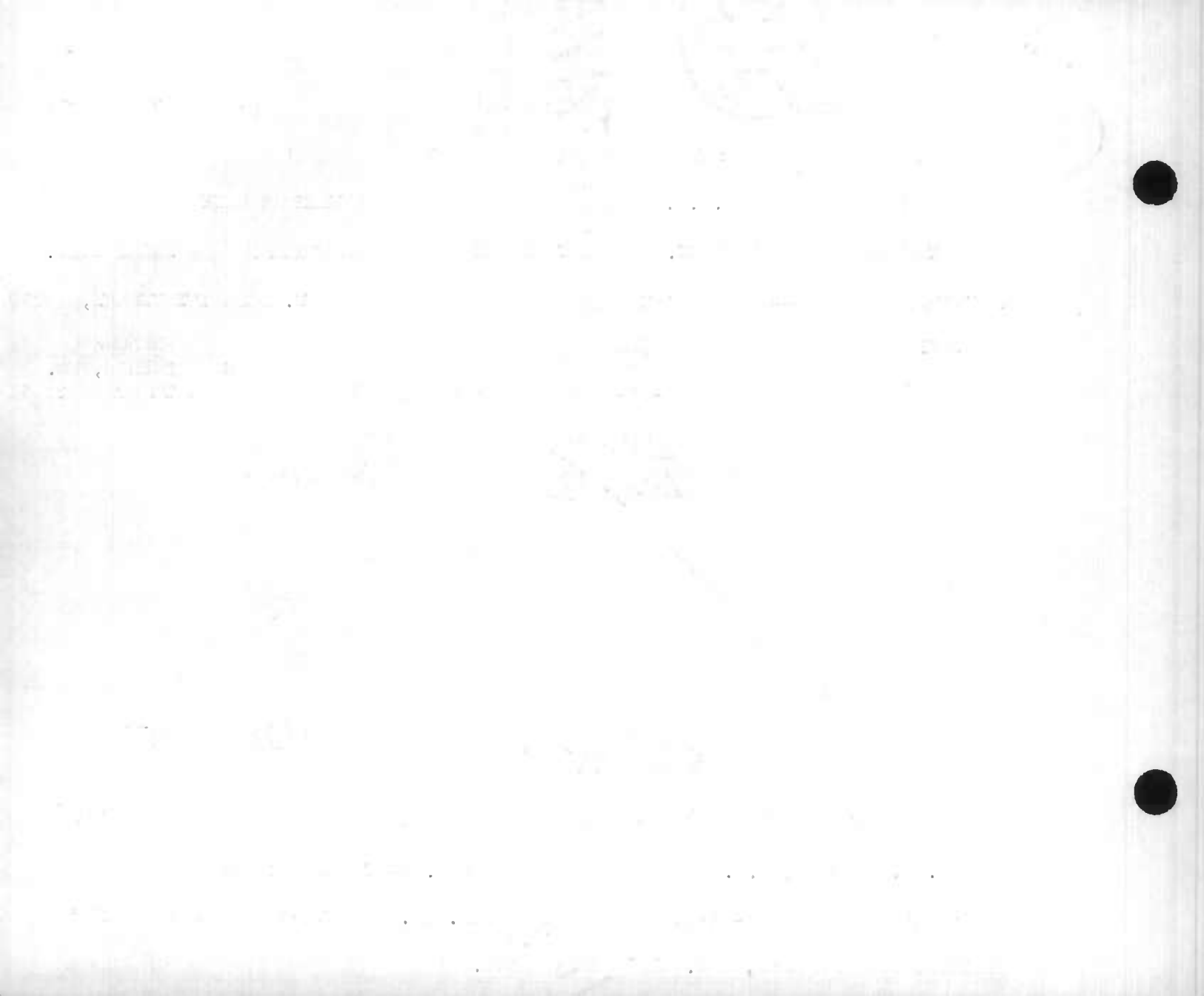
8 5 0 1 6 0 0

1- FOR  
STATE  
REGISTRAR

REG. NO.

|   |  |  |   |   |   |  |   |  |                  |  |
|---|--|--|---|---|---|--|---|--|------------------|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br><b>MICHAEL SWIDOWICH</b>   |  |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>01 28 85</b>                |   |   | 2b. HOUR<br><b>6:04 AM</b>   |   |  |                  |  |
| 3. SEX<br><b>MALE</b>   |  | 4. RACE<br><b>WHITE</b>  |   | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>11 01 03</b>   |   | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>81</b> YRS.  |   | IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS.<br>HOURS MIN.   |                  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>RUSSIA</b>  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>  |   | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>BALTIMORE CITY</b> MD.  |   |  |                  |  |
| 10. CITY OR TOWN OF DEATH<br><b>BALTIMORE</b>   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>3391 ST. BENEDICT STREET</b> |   |   |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>LONGSHOREMAN</b>  |   | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>JARKA CORP.</b>  |                  |  |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE<br><b>MARYLAND</b>   |  |  | 13b. COUNTY<br><b>---</b>   |   | 13c. CITY OR TOWN<br><b>BALTIMORE</b>   |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |                  |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>JOHN SWIDOWICH</b>   |  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>SUCHA UNKNOWN</b> |   |   | 13e. STREET ADDRESS / ZIP CODE<br><b>3391 ST. BENEDICT STREET, 21229</b>   |   |  |                  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>NO</b>   |  |  | 16b. SOCIAL SECURITY NO.<br><b>214-01-0793</b>                        |   | 17. INFORMANT<br>ADDRESS<br><b>SHIRLEY SWIDOWICH 506 ELIZABETH ROAD 21061</b> |  |   |  | GLEN BURNIE, MD. |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Possible acute myocardial infarction</u><br>DUE TO, OR AS A CONSEQUENCE OF (b) <u>ASCVD</u><br>DUE TO, OR AS A CONSEQUENCE OF (c) _____<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. |  |  |   |   |   |  |   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH   |                  |  |
|   |  |  |   |   |   |  |   |  |                  |  |
|   |  |  |   |   |   |  |   |  |                  |  |
|   |  |  |   |   |   |  |   |  |                  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: _____  |  |  |   |   |   |  |   |  |                  |  |
| 19a. DATE OF OPERATION  |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                      |   |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>  |   | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |                  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19            |   |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)   |   |  |                  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK  |  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY OFFICE, FARM, ETC.) |   |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE  |   |  |                  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>1/28</u> , 19 <u>85</u> , to <u>1/28</u> , 19 <u>85</u> , that (I) (we) last saw the deceased alive on <u>1/28</u> , 19 <u>85</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did not) view the body after death.            |  |  |   |   |   |  |   |  |                  |  |
| 22b. SIGNATURE<br><u>Beltran</u> MD.  |  |  |   |   |   | DEGREE<br>ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |   | 22c. DATE SIGNED<br><u>1/29/85</u>   |                  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>J. A. BELTRAN, M.D.</b>   |  |  |   |   |   | 22e. ADDRESS<br><b>1940 W. BALTIMORE STREET</b>  |   |  |                  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>BURIAL</b>   |  |  | 23b. DATE<br><b>01-31-85</b>  |   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>MEADOWRIDGE MEM. PK.</b>             |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>ELKRIDGE HOWARD MARYLAND</b>                   |  |                  |  |
| 24. FUNERAL DIRECTOR<br>NAME ADDRESS<br><b>HUBBARD FUNERAL HOME, INC. 4107 WILKENS AVE.</b>   |  |  |   |   |   | 25a. DATE REC'D. BY REGISTRAR<br><b>JAN 30 1985</b>  |   | 25b. REGISTRAR'S SIGNATURE<br><u>Julia Davidson-Rodriguez</u>  |                  |  |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked on item 18 shows any injury, or other traumatic event, the medical examiner must be notified of once.

1- FOR  
STATE  
REGISTRAR

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|   |  |   |  |   |   |   |  |  |  |                                  |  |
|---|--|---|--|---|---|---|--|--|--|----------------------------------|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>Minnie Sykes   |  |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br>1 12 85                         |   |   | 2b. HOUR<br>11:30 AM  |  |  |  |                                  |  |
| 3. SEX<br>Female  |  | 4. RACE<br>White  |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>Jan 10 1897   |   | 6. AGE (IN YEARS LAST BIRTHDAY)<br>88 YRS   |  | 7. IF UNDER 1 YEAR<br>MONTHS DAYS  |  | 8. IF UNDER 24 HRS<br>HOURS MIN. |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Balt. Maryland   |  | 7b. CITIZEN OF WHAT COUNTRY?<br>USA   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Baltimore City MD.                                      |  |  |  |                                  |  |
| 10. CITY OR TOWN OF DEATH<br>Baltimore  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>Levindale, Belvedere Ave., 21215 |  |   |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Housewife                   |  | 12b. KIND OF BUSINESS OR INDUSTRY  |  |                                  |  |
| 13a. STATE<br>Maryland  |  | 13b. COUNTY   |  | 13c. CITY OR TOWN<br>Baltimore  |   | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 13e. STREET ADDRESS<br>5325 Nelson Ave. 21215  |  |                                  |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>Lewis Horowitz  |  |   |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Sara   |   |   |  |  |  |                                  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br>No  |  | 16b. SOCIAL SECURITY NO.<br>216-09-8237B  |  | 17. INFORMANT<br>ADDRESS<br>Harry Sykes 3410 Courtleigh Dr., 21207  |   |   |  |  |  |                                  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) Myocardial insufficiency<br>DUE TO, OR AS A CONSEQUENCE OF<br>Arteriosclerotic cardiovascular disease yrs.<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c)<br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br>weeks |  |   |  |   |   |   |  |  |  |                                  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a  |  |   |  |   |   |   |  |  |  |                                  |  |
| 19a. DATE OF OPERATION  |  |   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                       |   |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>                       |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>                 |  |                                  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  |   | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19             |   |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)                  |  |  |  |                                  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK  |  |   | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) |   |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |  |  |                                  |  |
| 22a. I certify that (I (this hospital) attended the deceased from 11/2 19 85 to 11/8 19 77, and that (I (my) opinion death occurred on the date and hour and from the causes stated above, (I (we) did) (did not) saw the body after death.   |  |   |  |   |   |   |  |  |  |                                  |  |
| 22b. SIGNATURE<br>S. Stevenson  |  |   |  |   |   | DEGREE<br>MD  |  | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input checked="" type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |  | 22c. DATE SIGNED<br>11/12/85     |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)   |  |   |  |   |   | 22e. ADDRESS  |  |  |  |                                  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br>Burial  |  |   | 23b. DATE<br>1/14/85   |   | 23c. NAME OF CEMETERY OR CREMATORY<br>Beth Jacob Cemetery |   |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Finksburg Carroll MD   |  |                                  |  |
| 24. FUNERAL DIRECTOR<br>Hebrew Memorial F.H. 1100 Reisterstown Rd.<br>Pikesville, Md. 21208   |  |   |  |   |   | 25. DATE REC'D. BY REGISTRAR 25b. REGISTRAR'S SIGNATURE<br>JAN 14 1985                          |  |  |  |                                  |  |

BP



RECEIVED

20% COTTON FIB

CHITFAM



STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 5 0 1 6 0 2

1- FOR  
STATE  
REGISTRAR

REG. NO.

|  |  |   |  |   |   |
|--|--|---|--|---|---|
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>JOSEPH J. SZCZEPANIK</b>  |  |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>JANUARY 13, 1985</b>                       |   | 2b. HOUR<br><b>11:45PM</b>  |
| 3. SEX<br><b>Male</b>  | 4. RACE<br><b>White</b>  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>Feb. 5, 1925</b>   |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>59</b> YRS.   |   |
| 7a. BIRTHPLACE<br>(STATE OR FOREIGN)<br><b>MD.</b>   | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>   | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>BALTIMORE CITY</b> MD.                    |   |   |
| 10. CITY OR TOWN OF DEATH<br><b>BALTIMORE</b>  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>JOHNS HOPKINS HOSPITAL</b> |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Grocery</b>   | 12b. KIND OF BUSINESS OR INDUSTRY   |   |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br><b>MD.</b>   |  | 13b. COUNTY<br><b>Balto.</b>  | 13c. CITY OR TOWN<br><b>Balto.</b>   | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                                       |   |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Frank Szczepanik</b>  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Sophia 88XX UNKNOWN</b>   |  |   |   |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>Yes</b>   | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br><b>WWII 216-18-3154</b>   | 17. INFORMANT<br>ADDRESS<br><b>Eleanor Szczepanik 2331 Eastern Ave.</b>   |  |   |   |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>cardiopulmonary arrest</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.   |  |   |  |   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>45 minutes</b> |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a):<br><b>undiagnosed abdominal pain</b>  |  |   |  |   |   |
| 19a. DATE OF OPERATION<br><b>none</b>  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |   | 20a. AUTOPSY?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |   |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |  |   |   |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK   | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |   |   |
| 22a. I certify that (s) (this hospital) attended the deceased from <b>1/13</b> , 19 <b>85</b> , to <b>1/13</b> , 19 <b>85</b> , that (I) (we) lost saw the deceased alive on <b>1/13</b> , 19 <b>85</b> , and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. |  |   |  |   |   |
| 22b. SIGNATURE<br><b>Stephen C. Redd</b>   |  | DEGREE<br><b>MD</b>   |  | 22c. DATE SIGNED<br><b>1/14/85</b>  |   |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>Stephen C. Redd</b>  |  | 22e. ADDRESS<br><b>600 N. Wolfe St. Baltimore, MD</b>   |  |   |   |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>Burial</b>  | 23b. DATE<br><b>1-17-85</b>  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>St. Stanislaus</b>   | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Balto. Md.</b>                      | 23e. DATE REC'D. BY REGISTRAR<br><b>JAN 16 1985</b>   |   |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>John M. Weber &amp; Sons Inc.</b>   |  | ADDRESS<br><b>401 S. Chester St.</b>  |  | 25. REGISTRAR'S SIGNATURE<br><b>Julia Davidson-Randall</b>  |   |

RELEASED NON-MED PER DR. KAUFMAN - PER MR. GRAY

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician, it should be detached for use on the burial/transfer permit. Then please remove carbon 2 & 3 and file within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal of the body.

IMPORTANT: If item 21 is marked or item 18 shows any injury or other significant event, the medical examiner must be notified at once.

BP

NAVY DEPT  
RECEIVED  
MAR 19 1945  
U.S. NAVY

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 5 0 1 6 0 3

REG. NO.

1 - FOR  
STATE  
REGISTER

|   |  |   |  |  |   |
|---|--|---|--|--|---|
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>REV. ELIGUS SZOTT</b>  |  |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>JANUARY 16, 1985</b>                       |  | 2b. HOUR<br><b>10:44</b>                              |
| 3. SEX<br><b>MALE</b>   | 4. RACE<br><b>WHITE</b>  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>JUNE 19, 1911</b>  |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>73</b> YRS.                                    |   |
| 7a. BIRTHPLACE<br>(STATE OR FOREIGN COUNTRY)<br><b>MICHIGAN</b>   | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED<br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>BALTIMORE CITY</b> MD.                    |   |
| 10. CITY OR TOWN OF DEATH<br><b>BALTIMORE</b>   | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>JOHNS HOPKINS HOSPITAL</b> |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>PRIEST</b>    |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>RELIGIOUS</b> |
| 13a. STATE<br><b>MARYLAND</b>   | 13b. COUNTY<br><b>HOWARD</b>   | 13c. CITY OR TOWN<br><b>ELLCOTT</b>   | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> | 13e. STREET ADDRESS / ZIP CODE<br><b>FOLLY QUARTER RD. 21083</b>                     |   |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>ANDREW SZOTT</b>   |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>SOPHIE PIESOWICZ</b>  |  |  |   |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)<br><b>NO</b>   |  | 16b. SOCIAL SECURITY NO.<br><b>810 500 0105</b>   |  | 16c. INFORMANT ADDRESS<br><b>REV. ALEX CYMERMAN 1300 DUNDALK AVE.</b>                |   |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Asystole</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <b>sepsis, chronic ventilator dependence</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <b>Post op complication</b><br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>0-3 min</b><br><b>46 days</b><br><b>46 days</b> |  |   |  |  |   |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)<br><b>Acute Jaundice, mild Liver failure, Delirium</b>   |  |   |  |  |   |
| 19a. DATE OF OPERATION<br><b>11/26/84</b>   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED<br><b>metastatic cancer</b>  |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |   |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)       |   |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                    |   |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>10/29/84</b> , 19 <b>84</b> , to <b>1/16</b> , 19 <b>85</b> , that (I) (we) last saw the deceased alive on <b>1/16</b> , 19 <b>85</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.  |  |   |  |  |   |
| 22b. SIGNATURE<br><b>Samuel Dwight Lyon</b>   |  | DEGREE<br><b>Attending Physician</b>  |  | 22c. DATE SIGNED<br><b>1/16/85</b>   |   |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>Samuel Dwight Lyon</b>  |  | 22e. ADDRESS<br><b>Johns Hopkins Hospital</b>   |  |  |   |
| 23a. BURIAL, CREMATION, REMOVAL<br>(CHECK ONE)<br><b>BURIAL</b>   |  | 23b. DATE<br><b>1/18/85</b>   |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>ST. HELENE'S</b>                            |   |
| 23d. LOCATION<br>(CITY OR TOWN) COUNTY STATE<br><b>DETROIT MICH.</b>  |  | 25a. DATE REC'D. BY REGISTRAR<br><b>JAN 18 1985</b>   |  | 25b. REGISTRAR'S SIGNATURE<br><b>John Davidson-Randall</b>                           |   |
| 24. FUNERAL DIRECTOR<br>NAME ADDRESS<br><b>Raymond L. Kaczorowski 2525 FLEET ST.</b>  |  |   |  |  |   |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be completed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician, it should be detached for use as the burial-transit permit. Then please remove card for copy to the State Dept. of Health and Mental Hygiene prior to burial, cremation, or other disposition. IMPORTANT: If item 21 is marked accident, injury, or other traumatic event, the medical examiner must be notified and a change of cause of death may be required.

REVISED  
FALL 1968

3 573 40 01

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP

DHMH - 17  
(VR A15 ME (5))  
20M 4/82

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

1- FOR  
STATE  
REGISTRAR

|  |                     |  |  |   |  |   |  |   |   |  |  |
|--|---------------------|--|--|---|--|---|--|---|---|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br><b>GEORGE ROBERT TABOR</b>  |                     |  |  |   |  | 2a. DATE KNOWN OF DEATH<br>ESTIMATED <input checked="" type="checkbox"/> MONTH DAY YEAR<br><b>1 24 1985</b> |  |   | 2b. HOUR<br><b>4:11 P M</b>   |  |  |
| 3. SEX<br><b>M</b>   | 4. RACE<br><b>W</b> | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>3/11/29</b>   | 6. AGE (IN YEARS)<br>LAST BIRTHDAY<br><b>55</b> YRS. | IF UNDER 1 YR.<br>MONTHS DAYS<br><b>0 0</b>   | IF UNDER 24 HRS.<br>HOURS MIN.<br><b>0 0</b> | 2c. DATE PRONOUNCED DEAD<br>MONTH DAY YEAR<br><b>1 24 1985</b>  |  |   | 2d. HOUR<br><b>4:11 P M</b>   |  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>MD</b>   |                     | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore City</b> MD.   |  |   |   |  |  |
| 10. CITY OR TOWN OF DEATH<br><b>Baltimore</b>  |                     | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Church Hospital</b> |  |   |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Welder - Industrial Mfg.</b>            |  |   | 12b. KIND OF BUSINESS OR INDUSTRY   |  |  |
| 13a. USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>STATE<br><b>MD</b>  |                     | 13b. COUNTY<br><b>Balto.</b>   |  | 13c. CITY OR TOWN<br><b>Balto.</b>  |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>             |  | 13e. STREET ADDRESS<br><b>5500 Ready Ave., 21212</b>                                |   |  |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>George Cleveland</b>  |                     |  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Elizabeth Brown</b>   |  |   |  |   |   |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO, OR UNKNOWN)<br><b>Yes</b>  |                     | (IF YES, GIVE WAR OR DATES)<br><b>WW II</b>  |  | 16b. SOCIAL SECURITY NO.<br><b>220 20 5586</b>  |  | 17. INFORMANT ADDRESS<br><b>Craig B. Tabor, Balto., MD</b>  |  |   |   |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Arteriosclerotic cardiovascular disease</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last:<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____  |                     |  |  |   |  |   |  |   |   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a):  |                     |  |  |   |  |   |  |   |   |  |  |
| 19a. DATE OF OPERATION   |                     |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?   |  |   |  | 20. AUTOPSY?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |   |  |  |
| 21a. EXTERNAL CAUSE WAS<br>UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH   |                     |  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)                               |  |   |   |  |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  |                     |  |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)   |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |   |   |  |  |
| 22a. I certify that I took charge of the deceased described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: <b>Natural causes</b> <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> |                     |  |  |   |  |   |  |   |   |  |  |
| ACTUAL SIGNATURE<br><i>Thomas D. Smith</i>   |                     |  |  | TITLE (SPECIFY)<br><b>Acting Chief</b>  |  |   |  | DATE SIGNED<br><b>1-25-85</b>   |   |  |  |
| EXAMINER'S NAME<br>(TYPE OR PRINT)<br><b>Thomas D. Smith, M.D.</b>   |                     |  |  | ADDRESS<br><b>111 Penn St., Balto., Md. 21201</b>   |  |   |  |   |   |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>Burial</b>   |                     |  |  | 23b. DATE<br><b>1/28/85</b>   |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Holly Hill Cemetery</b>  |  |   | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Baltimore County, MD</b> |  |  |
| 24. FUNERAL DIRECTOR NAME<br><b>Henry W. Jenkins &amp; Sons Co.</b>  |                     |  |  |   |  | 25a. DATE REC'D. BY REGISTRAR<br><b>JAN 28 1985</b>   |  | 25b. REGISTRAR'S SIGNATURE  |   |  |  |
| 4905 York Road Balto., MD 21212  |                     |  |  |   |  |   |  |   |   |  |  |

MEDICAL CERTIFICATION

Wolter - Industrial Mfg.

2500 Reedy Ave., Bldg. 12

Elizbeth

Cleveland

George

Yes

WW II

2500 2550

Craig B. Tabor

Bldg. 12

Baltimore Court

Henry W. Jenkins & Sons Co.

2112

2112

2112

2112



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be returned by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

Film G603 item 5

1- FOR 5/17/85 rja  
STATE REGISTRAR

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|   |  |  |  |  |  |   |  |   |  |                  |  |
|---|--|--|--|--|--|---|--|---|--|------------------|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br><b>Mr. Jerry Allen Tasker Sr.</b>  |  |  |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>January 2 1985</b>   |  |   |  | 2b. HOUR<br><b>605</b> M  |  |                  |  |
| 3. SEX<br><b>Male</b>   |  | 4. RACE<br><b>Caucasian</b>  |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>July 17 1946</b>  |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>38</b> YRS.   |  | IF UNDER 1 YEAR<br>MONTHS DAYS HOURS MIN.   |  | IF UNDER 24 HRS. |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>West Virginia</b>   |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>   |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>        |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore City</b> MD.                               |  |   |  |                  |  |
| 10. CITY OR TOWN OF DEATH<br><b>Baltimore</b>   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>St. Agnes Hospital</b> |  |  |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Unemployed</b>           |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>disabled</b>  |  |                  |  |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13b. STATE<br><b>Maryland</b>   |  |  |  | 13c. CITY OR TOWN<br><b>Woodlawn</b>   |  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  | 13e. STREET ADDRESS / ZIP CODE<br><b>2020 Summit Ave. 21207</b>   |  |                  |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Edward S. Tasker</b>   |  |  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Margaret Elizabeth Dewitt</b>  |  |   |  | 16. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>No</b>  |  |                  |  |
| 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br><b>213-44-8022</b>   |  |  |  | 17. INFORMANT<br>NAME ADDRESS<br><b>Mrs. Velma Jane Tasker 21207</b><br><b>2020 Summit Ave. Baltimore Maryland</b>   |  |   |  | 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Chronic Renal Failure</b><br>DUE TO, OR AS A CONSEQUENCE OF (b) <b>CONGESTIVE Heart Failure</b><br>DUE TO, OR AS A CONSEQUENCE OF (c) <b></b> |  |                  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <b></b>  |  |  |  |  |  |   |  |   |  |                  |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  |  |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>            |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>  |  |                  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>19</b>   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)   |  |   |  |   |  |                  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK   |  | 21e. PLACE OF INJURY<br>(AT HOME STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE  |  |   |  |   |  |                  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>12-23</b> , 19 <b>84</b> , to <b>1-2</b> , 19 <b>85</b> , that (I) (we) last saw the deceased alive on <b>1-2</b> , 19 <b>85</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |  |  |  |  |  |   |  |   |  |                  |  |
| 22b. SIGNATURE<br><b>Kenneth Williams</b>   |  |  |  | DEGREE<br><b>MD.</b><br>ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> |  |   |  | 22c. DATE SIGNED  |  |                  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)   |  |  |  | 22e. ADDRESS   |  |   |  |   |  |                  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>Burial</b>   |  | 23b. DATE<br><b>1-5-85</b>   |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Crest Lawn Cemetery</b>   |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>W Friendship Howard Maryland</b>               |  |   |  |                  |  |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>Loring Byers Funeral Directors, Inc.</b>   |  |  |  |  |  | 25a. DATE REC'D. BY REGISTRAR<br><b>JAN 4 1985</b>  |  | 25b. REGISTRAR'S SIGNATURE<br><b>Handell</b>  |  |                  |  |
| 2728 Liberty Road Randallstown, Maryland 21133  |  |  |  |  |  |   |  |   |  |                  |  |

BP

8226 Liberty Road Philadelphia, Maryland 21133  
 Leasing Space Rental Department, Inc.  
 1-2-68  
 Dear Loan Company  
 We understand Howard Hughes

8226  
 8226  
 8226

No  
 Howard J. Tamm  
 513-21-0021  
 5000 Walnut Ave.  
 Baltimore  
 21201

Maryland  
 Baltimore  
 Woodrow  
 5000 Walnut Ave.  
 21201

Baltimore  
 34. Agnes Hospital  
 Baltimore City  
 21201

1967

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified on page 3.

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8501606

FOR  
STATE  
REGISTRAR

REG. NO.

|   |   |   |  |  |   |
|---|---|---|--|--|---|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>FIRST MIDDLE LAST<br><b>Edward Taylor</b>  |   |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>1 21 85</b>                                |  | 2b. HOUR<br><b>8 AM</b>   |
| 3. SEX<br><b>M</b>  | 4. RACE<br><b>B</b>   | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>10 22 39</b>   |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>55</b> YRS.  | IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS.<br>HOURS MIN.                                |
| 7a. BIRTHPLACE<br>(STATE OR FOREIGN COUNTRY)<br><b>MO</b>   | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore City</b> MD.                    |  |   |
| 10. CITY OR TOWN OF DEATH<br><b>Baltimore</b>   | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Good Samaritan Hospital</b> |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)                     | 12b. KIND OF BUSINESS OR INDUSTRY  |   |
| 13a. STATE<br><b>MD</b>   |   |   | 13b. COUNTY  | 13c. CITY OR TOWN<br><b>Baltimore</b>  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>— — —</b>  |   |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Mamie Stewart</b>                |  |   |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>No</b>   |   | 16b. SOCIAL SECURITY NO.<br><b>217-24-4688</b>  |  | 17. INFORMANT ADDRESS<br><b>Delores Kelly 2308 E. Lafayette Ave.</b>   |   |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Cardiopulmonary arrest</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. |   |   |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>1/2 hour</b>                                 |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (d)<br><b>Chronic renal failure, Chronic hepatitis B.</b>   |   |   |  |  |   |
| 19a. DATE OF OPERATION<br><b>1/19/85</b>  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED<br><b>Clotted dialysis fistula</b>   |   | 20a. AUTOPSY?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |   |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>19</b>  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)  |  |  |   |
| 21d. INJURY OCCURRED<br>WHERE <input type="checkbox"/> NOT WHERE <input type="checkbox"/><br>AT WORK AT WORK  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |  |   |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>January 2, 1985</b> , to <b>January 21, 1985</b> , that (I) (we) lost saw the deceased alive on <b>January 21, 1985</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (I) (we) (did not) view the body after death.             |   |   |  |  |   |
| 22b. SIGNATURE<br><b>S. Kaufman</b>   |   | DEGREE<br><b>M.D.</b>   |  | 22c. DATE SIGNED   |   |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>Scott Kaufman</b>   |   | 22e. ADDRESS  |  |  |   |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>Burial</b>   | 23b. DATE<br><b>1/25/85</b>   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Mt. Zion Cem.</b>  |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Baltimore MD</b>  |   |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>Wm. C. March F/H 1101 E. North Ave.</b>  |   |   | 25a. DATE REC'D. BY REGISTRAR<br><b>JAN 23 1985</b>                                  |  |   |
|   |   |   | 25b. REGISTRAR'S SIGNATURE<br><b>John Davidson-Randall</b>                           |  |   |

BP

Page 1 of 1

12/12/2020

12/12/2020

12/12/2020

12/12/2020

12/12/2020

12/12/2020

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER, ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

07/84  
25MBP \_\_\_\_\_  
DHMH - 17  
(VR A15 ME (5))

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>MEDICAL EXAMINER'S CERTIFICATE OF DEATH  |                     |   |  |   |                                |   |   |   |                              | REG. NO. |  |
|--|---------------------|---|--|---|--------------------------------|---|---|---|------------------------------|----------|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT) FIRST MIDDLE LAST<br><b>IRVIN J TAYLOR</b>   |                     |   |  |   |                                |   | 2a. DATE KNOWN OF DEATH<br>ESTIMATED <input checked="" type="checkbox"/> MONTH DAY YEAR<br><b>1-25-85</b> |   | 2b. HOUR<br>M<br><b>7:55</b> |          |  |
| 3. SEX<br><b>M</b>   | 4. RACE<br><b>W</b> | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>3/20/28</b>  | 6. AGE (IN YEARS)<br>LAST BIRTHDAY<br><b>56</b> YRS. | IF UNDER 1 YR<br>MONTHS DAYS  | IF UNDER 24 HRS.<br>HOURS MIN. | 2c. DATE PRONOUNCED DEAD<br>MONTH DAY YEAR<br><b>1-25-85</b>                                    |   | 2d. HOUR<br>M<br><b>7:55</b>  |                              |          |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>PA.</b>  |                     | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>  |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |                                | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore City</b> MD.                               |   |   |                              |          |  |
| 10. CITY OR TOWN OF DEATH<br><b>Baltimore</b>  |                     | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Johns Hopkins Hospital</b> |  |   |                                | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)                                   |   | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>STEEL</b>                                   |                              |          |  |
| 13a. USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE<br><b>MD</b>   |                     | 13b. COUNTY<br><b>BALTO</b>   |  | 13c. CITY OR TOWN<br><b>BALTO</b>   |                                | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |   | 13e. STREET ADDRESS<br><b>21213 3702 BELAIR RD</b>                                  |                              |          |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>JOSEPH TAYLOR</b>   |                     |   |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>JNK</b>   |                                |   |   |   |                              |          |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO, OR UNKNOWN) (IF YES, GIVE WAR OR DATES)<br><b>YES WW II</b>  |                     | 16b. SOCIAL SECURITY NO.<br><b>218 22 9344</b>  |  | 17. INFORMANT<br>ADDRESS<br><b>DAVID TAYLOR 8107 LYNDEN AVE</b>   |                                |   |   |   |                              |          |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Arteriosclerotic cardiovascular disease</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____<br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH            |                     |   |  |   |                                |   |   |   |                              |          |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).  |                     |   |  |   |                                |   |   |   |                              |          |  |
| 19a. DATE OF OPERATION   |                     | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?   |  |   |                                |   |   | 20. AUTOPSY?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |                              |          |  |
| 21a. EXTERNAL CAUSE WAS<br>UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH   |                     | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)   |                                |   |   |   |                              |          |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  |                     | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)   |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |                                |   |   |   |                              |          |  |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> . |                     |   |  |   |                                |   |   |   |                              |          |  |
| ACTUAL SIGNATURE<br><b>Margaret Bre Yell</b>   |                     |   |  | TITLE (SPECIFY)<br><b>Assistant</b>   |                                |   |   | DATE SIGNED<br><b>1-26-85</b>   |                              |          |  |
| EXAMINER'S NAME<br>(TYPE OR PRINT)<br><b>Margarita A. Korell, M.D.</b>   |                     |   |  | ADDRESS<br><b>111 Penn Street</b>   |                                |   |   |   |                              |          |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>BURIAL</b>  |                     | 23b. DATE<br><b>1/29/85</b>   |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>ST. STANIS LAUS</b>  |                                |   |   | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>BALTO. MD.</b>                     |                              |          |  |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>J.G. CONNELLY</b>   |                     |   |  | ADDRESS<br><b>300 MACE</b>  |                                | 25a. DATE REC'D. BY REGISTRAR<br><b>JAN 30 1985</b>   |   | 25b. REGISTRAR'S SIGNATURE<br><b>J. Davidson</b>                                    |                              |          |  |



STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8501608

FOR  
1 - STATE  
REGISTRAR

REG. NO.

|  |  |  |  |  |  |  |  |  |
|--|--|--|--|--|--|--|--|--|
| 1 DECEASED NAME<br>(TYPE OR PRINT)<br><b>MARIE TAYLOR</b>  |  |  | 2a DATE OF DEATH<br>MONTH DAY YEAR<br><b>JANUARY 14, 1985</b>  |  |  | 2b HOUR<br><b>12:51AM</b>  |  |  |
| 3 SEX<br><b>FEMALE</b>   |  |  | 4 RACE<br><b>NEGROID</b>   |  |  | 5 DATE OF BIRTH<br>MONTH DAY YEAR<br><b>9-23-24</b>  |  |  |
| 7a BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>VIRGINIA</b>  |  |  | 7b CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>   |  |  | 8 AGE (IN YEARS LAST BIRTHDAY)<br>YRS MONTHS DAYS<br><b>60</b>   |  |  |
| 10 CITY OR TOWN OF DEATH<br><b>BALTIMORE</b>   |  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>JOHNS HOPKINS HOSPITAL</b> |  |  | 9 BALTIMORE CITY OR COUNTY OF DEATH<br><b>BALTIMORE CITY MD.</b>   |  |  |
| 12a USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Housewife</b>  |  |  | 12b KIND OF BUSINESS OR INDUSTRY   |  |  |  |  |  |
| 13a STATE<br><b>md.</b>  |  |  | 13b COUNTY<br><b>Balto.</b>  |  |  | 13c CITY OR TOWN<br><b>Balto.</b>  |  |  |
| 13d INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>   |  |  | 13e STREET ADDRESS / ZIP CODE<br><b>1413 E. Preston St. 21213</b>  |  |  |  |  |  |
| 14 FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Richard William Sr.</b>  |  |  | 15 MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Nannie Redd</b>   |  |  |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)<br><b>NO</b>  |  |  | 16b SOCIAL SECURITY NO.<br><b>219-10-9406</b>  |  |  | 17 INFORMANT ADDRESS<br><b>ALFRED TAYLOR 1413 E. Preston</b>   |  |  |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Cardiopulmonary Distress</b><br>DUE TO, OR AS A CONSEQUENCE OF (b) _____<br>DUE TO, OR AS A CONSEQUENCE OF (c) _____<br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>one hour</b>                                     |  |  |  |  |  |  |  |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)<br><b>Cranial Artery Dissec.</b>  |  |  |  |  |  |  |  |  |
| 19a DATE OF OPERATION  |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  |  | 20a AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>  |  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)  |  |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  |  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |  |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE  |  |  |
| 22a. I certify that (1) (this hospital) attended the deceased from <b>1/14</b> 19 <b>85</b> , to <b>1/14</b> 19 <b>85</b> , that (1) (we) last saw the deceased alive on <b>1/14</b> 19 <b>85</b> , and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (1) (we) (did) (did not) view the body after death. |  |  |  |  |  |  |  |  |
| 22b. SIGNATURE<br><b>James E. Greenwald</b>  |  |  | DEGREE<br><b>MD PhD</b>  |  |  | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |  | 22c. DATE SIGNED<br><b>1/15/85</b>   |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>JAMES E. GREENWALD</b>   |  |  | 22e. ADDRESS<br><b>JOHNS HOPKINS HOSPITAL</b>  |  |  |  |  |  |
| 23a BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>BURIAL</b>  |  |  | 23b. DATE<br><b>1-19-85</b>  |  |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Baltimore Cem.</b>  |  |  |
| 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Balto. MD.</b>  |  |  | 24 FUNERAL DIRECTOR<br>NAME ADDRESS<br><b>Calvin B. Scruggs 1412 E. Preston St.</b>  |  |  | 25a. DATE REC'D. BY REGISTRAR<br><b>JAN 16 1985</b>  |  |  |
| 25b. REGISTRAR'S SIGNATURE<br><b>John L. ...</b>   |  |  |  |  |  |  |  |  |

RELEASED NON-MED PER DR. KAUFMAN PER MR. GRAY

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. It may be returned by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use in the burial transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 7 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked "unknown," the medical examiner must be notified.

BP



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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that this certificate be completed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 4 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed in this 24 hour office copy with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

85

01609

1. FOR  
STATE  
REGISTRAR

REG. NO.

|   |  |  |   |  |  |   |  |  |  |
|---|--|--|---|--|--|---|--|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>FIRST MIDDLE LAST<br><b>NORMAN TAYLOR</b>  |  |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>JAN. 27, 1985</b>   |  | 2b. HOUR<br>MIN.<br><b>5:45AM</b>  |   |  |  |  |
| 3. SEX<br><b>Male</b>   |  | 4. RACE<br><b>Black</b>  |   | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>Sept. 17- 95</b>  |  | 6. AGE (IN YEARS (LAST BIRTHDAY))<br>YRS. MONTHS DAYS<br><b>89 YRS.</b> |  |  |  |
| 7a. BIRTHPLACE<br>(STATE OR FOREIGN COUNTRY)<br><b>MD.</b>  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>  |   | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>BALTIMORE CITY</b> MD.       |  |  |  |
| 10. CITY OR TOWN OF DEATH<br><b>BALTIMORE</b>   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>JOHNS HOPKINS HOSPITAL</b>           |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Laborer</b>   |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>CONSTRUCTION</b>                |  |  |  |
| 13a. STATE<br><b>MD.</b>  |  |  | 13b. COUNTY   |  | 13c. CITY OR TOWN<br><b>Baltimore</b>  |   | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                            |  |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>UNKNOWN</b>  |  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Fairy Taylor</b>  |  | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>Yes</b>   |   |  | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br><b>W.W.I.</b>                               |  |
| 17. INFORMANT<br>ADDRESS<br><b>Clementine Dunn 1525 N. Milton Ave.</b>  |  |  | 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Cardiopulmonary Arrest</b><br>DUE TO, OR AS A CONSEQUENCE OF (b) <b>Metabolic Acidosis + hypertension</b><br>DUE TO, OR AS A CONSEQUENCE OF (c) <b>Pneumococcal Pneumonia</b> |  |  |   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>5 minutes</b><br><b>10 hours</b><br><b>36 hours</b> |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: <b>0</b>   |  |  |   |  |  |   |  |  |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |   | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19   |   | 21c. HOW INJURY OCCURRED<br>(ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)  |  |   |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE  |  |   |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>12/5/85</b> , 19 <b>85</b> , to <b>1/27</b> , 19 <b>85</b> , that (I) (we) lost saw the deceased alive on <b>1/27</b> , 19 <b>85</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above; (I) (we) (did) (did not) view the body after death. |  |  |   |  |  |   |  |  |  |
| 22b. SIGNATURE<br><b>Henry Paul Parkman</b>   |  | DEGREE<br>ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |   |  |  |   | 22c. DATE SIGNED<br><b>1/27/85</b>   |  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>PARKMAN, HENRY</b>  |  | 22e. ADDRESS<br><b>Johns Hopkins Hospital</b>  |   |  |  |   |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>Burial</b>   |  | 23b. DATE<br><b>1-31-85</b>  |   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>G. F. Veterans Cmty.</b>  |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE                              |  | 23e. DATE REC'D. BY REGISTRAR  |  |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>Randolph J. Collick</b>  |  | ADDRESS<br><b>24316 Oliver St.</b>   |   | 25a. DATE REC'D. BY REGISTRAR<br><b>FEB 1 1985</b>   |  | 25b. REGISTRAR'S SIGNATURE<br><b>Randolph J. Collick</b>                |  |  |  |



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STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8501610

|   |   |  |   |
|---|---|--|---|
| FOR<br>1- STATE<br>REGISTRAR  |   | REG. NO.   |   |
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>FIRST MIDDLE LAST<br>Rosalie Taylor  |   | 2a. DATE OF DEATH MONTH DAY YEAR<br>1 20 85<br>2b. HOUR<br>1030 P <sub>M</sub>   |   |
| 3. SEX<br>F   | 4. RACE<br>B  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>10 3 25  |   |
| 6. AGE (IN YEARS LAST BIRTHDAY)<br>59 YRS.  |   | 7. IF UNDER 1 YEAR<br>MONTHS DAYS HOURS MIN.<br>8. IF UNDER 24 HRS.<br>HOURS MIN.  |   |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>MD   | 7b. CITIZEN OF WHAT COUNTRY?<br>US  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Baltimore MD.  |   |
| 10. CITY OR TOWN OF DEATH<br>Baltimore  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>WYMAN PARK HEALTH SYSTEM | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>SEC.<br>12b. KIND OF BUSINESS OR INDUSTRY<br>DENTIST                                       |   |
| 13a. STATE<br>MD  | 13b. COUNTY<br>Baltimore  | 13c. CITY OR TOWN<br>Baltimore   | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>Zederick Johnson  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Janey Laural   | 13e. STREET ADDRESS ZIP CODE<br>3603 Copley Rd. Balto, MD 21215  |   |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)  | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br>217-20-8301  | 17. INFORMANT<br>ADDRESS<br>chart.   |   |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY<br>IMMEDIATE CAUSE (a) <u>widespread carcinomatosis</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <u>endometrial carcinoma</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____<br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><u>since 1983</u><br><u>since 1982</u>                         |   |  |   |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: _____  |   |  |   |
| 19a. DATE OF OPERATION  |   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |   |
| 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>   |   | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>                                     |   |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |   | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19   |   |
| 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1B, PART 1 OR PART 2)  |   | 21d. INJURY OCCURRED<br>WHITE <input type="checkbox"/> NOT WHITE <input type="checkbox"/><br>AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/> |   |
| 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE<br>J3  |   |
| 22a. I certify that (I) <u>this hospital</u> attended the deceased from <u>1/18/84</u> , 19 <u>84</u> , to <u>1</u> / <u>20</u> , 19 <u>85</u> , that (I) <u>we</u> saw the deceased alive on <u>1/20</u> , 19 <u>85</u> , and that in (my) <u>our</u> opinion death occurred on the date and hour and from the causes stated above, (I) <u>we</u> <u>did</u> <u>did not</u> view the body after death. |   |  |   |
| 22b. SIGNATURE<br>M. J. GOUVER, MD  |   | 22c. DATE SIGNED<br>1/20/85  |   |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>MYRNA I. GOVER   |   | 22e. ADDRESS<br>3100 WYMAN PARK DR. Balto 21211  |   |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br>Burial  | 23b. DATE<br>1-25-85  | 23c. NAME OF CEMETERY OR CREMATORY<br>Antietam Memorial Cen  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Balto. MD.  |
| 24. FUNERAL DIRECTOR<br>NAME ADDRESS<br>Blain Thompson Funeral Home 1915 W. Balto. St   |   | 25a. DATE REC'D. BY REGISTRAR<br>JAN 25 1985   |   |
| 25b. REGISTRAR'S SIGNATURE<br>Julia Davidson-Randall  |   |  |   |

BP \_\_\_\_\_

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 3 and 4 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the registrars, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 5 0 1 6 1 1

1- FOR  
STATE  
REGISTRAR

REG. NO.

|  |  |  |  |   |  |  |   |  |   |  |  |
|--|--|--|--|---|--|--|---|--|---|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br><b>Willie Teamer</b>  |  |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>01 11 85</b>                 |   |  | 2b. HOUR<br><b>12:10AM</b>   |   |  |   |  |  |
| 3. SEX<br><b>Female</b>  |  | 4. RACE<br><b>Black</b>  |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>05 16 00</b>   |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>84</b> YRS.                              |   | 7. IF UNDER 1 YEAR<br>MONTHS DAYS<br><b>00 00</b>  |   |  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>North Carolina</b>   |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>  |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore City</b> MD.              |   |  |   |  |  |
| 10. CITY OR TOWN OF DEATH<br><b>Baltimore</b>  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Mt. Vernon Care Center, Inc.</b> |  |   |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)               |   | 12b. KIND OF BUSINESS OR INDUSTRY  |   |  |  |
| 13a. STATE<br><b>Md</b>  |  |  | 13b. COUNTY  |   | 13c. CITY OR TOWN<br><b>Baltimore</b>                                |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 13e. STREET ADDRESS / ZIP CODE<br><b>633 Asquith St Apt. 11 C 21202</b> |  |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Willie McCoy</b>  |  |  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Cathy</b>   |  |  |   |  |   |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)<br><b>Unknown</b>   |  |  | 16b. SOCIAL SECURITY NO.<br><b>218-36-1129</b>                         |   | 17. INFORMANT ADDRESS<br><b>Cartilla Holbert 4812 Clayberry Ave.</b> |  |   |  |   |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>CARDIOPULMONARY FAILURE</b>  |  |  |  |   |  |  |   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH                            |  |  |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last:<br>DUE TO, OR AS A CONSEQUENCE OF (b) <b>RECENT CVA</b><br>DUE TO, OR AS A CONSEQUENCE OF (c) <b>OLD CVA (R), w/ L Hemiparesis</b>  |  |  |  |   |  |  |   |  |   |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (b)<br><b>ASCVD, CHF, DEGENERATIVE JOINT DISEASE</b>  |  |  |  |   |  |  |   |  |   |  |  |
| 19a. DATE OF OPERATION   |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                       |   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>      |   | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |   |  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. <b>19</b>      |   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) |   |  |   |  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK   |  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) |   |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                              |   |  |   |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>01/11/85</b> to <b>01/11/85</b> , (that (I) (we) last saw the deceased alive on <b>01/11/85</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |  |  |  |   |  |  |   |  |   |  |  |
| 22b. SIGNATURE<br><b>A. Enrique</b> MD<br>DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>  |  |  |  |   |  |  |   |  | 22c. DATE SIGNED  |  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>A. ENRIQUE</b>   |  |  |  |   |  | 22e. ADDRESS<br><b>2435 W BELVEDERE AVE BALTO MD, 21234</b>                    |   |  |   |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>BURIAL</b>   |  |  | 23b. DATE<br><b>1/16/85</b>  |   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Mount Auburn Cem.</b>       |  |   | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Baltimore, Md.</b>  |   |  |  |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>Wm C March F/H Inc.</b>   |  |  |  |   |  | 25a. DATE REC'D. BY REGISTRAR<br><b>JAN 14 1985</b>                            |   | 25b. REGISTRAR'S SIGNATURE<br><b>Julia Davidson-Randall</b>  |   |  |  |

MEDICAL CERTIFICATION

BP

01:11 28 11 19

DEED

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Mr. Vernon Carl Cannon, I.

State

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STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

1- FOR  
STATE  
REGISTRAR

REG. NO.

|   |  |  |  |   |  |   |  |
|---|--|--|--|---|--|---|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>WILLIAM A. TEFFNER</b>                               |  |  | 2a. DATE OF DEATH<br>MONTH <b>1</b> DAY <b>30</b> YEAR <b>85</b> |   |  | 2b. HOUR<br><b>2:15 P.M.</b>  |  |
| 3. SEX<br><b>M</b>  |  | 4. RACE<br><b>Caucasian</b>  |  | 5. DATE OF BIRTH<br>MONTH <b>12</b> DAY <b>07</b> YEAR <b>15</b>  |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>69</b> YRS.   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>MARYLAND</b>                                |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.</b>  |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>BALTIMORE City</b> MD.                               |  |
| 10. CITY OR TOWN OF DEATH<br><b>BALTIMORE</b>   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>FRANCIS SCOTT KEY MEDICAL CENTER</b> |  |   |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>SEAMAN</b>               |  |
|   |  |  |  |   |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>MERCHANT MARINES</b>                                    |  |
| 13. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) |  |  |  |   |  |   |  |
| 13a. STATE<br><b>MARYLAND</b>   |  | 13b. COUNTY<br><b>BALTIMORE</b>  |  | 13c. CITY OR TOWN<br><b>LANSDOWNE</b>   |  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |
| 14. FATHER'S NAME<br>FIRST <b>AUGUST</b> MIDDLE <b>TEFFNER</b> LAST <b>TEFFNER</b>          |  | 15. MOTHER'S MAIDEN NAME<br>FIRST <b>MAMMIE</b> MIDDLE <b>MILLER</b> LAST <b>MILLER</b>  |  | 13e. STREET ADDRESS / ZIP CODE<br><b>273 CLYDE AVENUE, 21227</b>  |  |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>NO</b>           |  | 16b. SOCIAL SECURITY NO.<br><b>219-03-7572</b>   |  | 17. INFORMANT<br><b>IDA M. TEFFNER</b> ADDRESS<br><b>273 CLYDE AVENUE, 21227</b>  |  |   |  |

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) **Pancreatic cancer**

DUE TO, OR AS A CONSEQUENCE OF

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last

(b)

DUE TO, OR AS A CONSEQUENCE OF

(c)

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: (a)

|  |  |  |  |  |  |  |  |
|--|--|--|--|--|--|--|--|
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                       |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>  |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19             |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)   |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE  |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>1/1</b> , 19 <b>85</b> , to <b>1/30</b> , 19 <b>85</b> , that (I) (we) lost <b>saw</b> the deceased alive on <b>1/28</b> , 19 <b>85</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |  |  |  |  |  |  |  |
| 22b. SIGNATURE<br><b>KIN-SING AU</b>   |  |  |  | DEGREE<br>ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> |  | 22c. DATE SIGNED<br><b>1/30/85</b>   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>KIN-SING AU</b>  |  |  |  | 22e. ADDRESS<br><b>Berkham Center</b>  |  |  |  |

|  |  |                              |  |  |  |  |  |
|--|--|------------------------------|--|--|--|--|--|
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>BURIAL</b>                        |  | 23b. DATE<br><b>02-02-85</b> |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>LOUDON PARK</b> |  | 23d. LOCATION<br>CITY OR TOWN <b>BALTIMORE CITY</b> COUNTY <b>MARYLAND</b> STATE |  |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>HUBBARD FUNERAL HOME, INC., 4107 WILKENS AVE.</b> |  |                              |  | 25a. DATE RECEIVED BY REGISTRAR<br><b>FEB 1 1985</b>     |  | 25b. REGISTRAR'S SIGNATURE   |  |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with in 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked as item 18 above, any injury, or other traumatic event, the medical examiner must be notified at once.

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TO THE DIRECTOR OF THE BUREAU OF LAND MANAGEMENT  
FROM THE CHIEF OF THE DISTRICT OF COLUMBIA  
SUBJECT: [Illegible]  
[The remainder of the document contains several paragraphs of extremely faint, illegible text, likely a memorandum or official correspondence.]

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

85 01613

| FOR STATE REGISTRAR   |  |  |  | REG. NO.  |  |  |  |
|---|--|--|--|---|--|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>WALTER CARL P. THIELE</b>  |  |  |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>1-8-85</b>  |  | 2b. HOUR<br><b>1015</b> M  |  |
| 1. SEX<br><b>MALE</b>   |  | 4. RACE<br><b>WHITE</b>  |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>8 13 09</b>  |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>75</b> YRS.  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN)<br><b>BALTO MD</b>  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>BALTO CITY</b> MD.  |  |
| 10. CITY OR TOWN OF DEATH<br><b>BALTO MD</b>  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>ST. AGNES HOSPITAL</b> |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Architect</b>  |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>Home Building</b>  |  |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE <b>MD</b> 13a. CITY OR TOWN <b>BALTO</b>   |  | 13b. CITY OR TOWN<br><b>Catonsville</b>  |  | 13c. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  | 13d. STREET ADDRESS / ZIP CODE<br><b>2005 CLIFDEN RD, 21228</b>  |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Paul Thiele</b>  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Frieda Siebert</b>   |  | 16. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)<br><b>NO</b>   |  |  |  |
| 16a. SOCIAL SECURITY NO.<br><b>216 09 7062</b>  |  | 17. INFORMANT ADDRESS<br><b>Herman O. Thiele - Baltimore, Md. 21227</b>  |  |   |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>BRAIN ANOXIA</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last:<br>(b) <b>Cardio Respiratory Arrest</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <b>Coronary Artery Disease S/P Myocardial Infarction</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a).<br><b>Hypertension, Hyperlipidemia and Hyperuricemia</b> |  |  |  |   |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)  |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |  |  |
| 22a. I certify that (this hospital) attended the deceased from <b>1/2</b> 19 <b>85</b> , to <b>1/8</b> 19 <b>85</b> , that (we) last saw the deceased alive on <b>1/8</b> 19 <b>85</b> , and that in (our) opinion death occurred on the date and hour and from the causes stated above, (if we) (did) (did not) view the body after death.   |  |  |  |   |  |  |  |
| 22b. SIGNATURE<br><b>Andrew Gordon MD</b>   |  |  |  | DEGREE<br>ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>        |  | 22c. DATE SIGNED<br><b>1/8/85</b>  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>Andrew Gordon MD</b>  |  |  |  | 22e. ADDRESS<br><b>Saint Agnes Hosp. 900 Caton Ave Balt. Md</b>   |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>Burial</b>   |  | 23b. DATE<br><b>1/11/85</b>  |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Loudon Park Cemetery</b>   |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Baltimore Md.</b>   |  |
| 24. FUNERAL DIRECTOR<br>NAME ADDRESS<br><b>Leroy M. &amp; Russell C. Witzke Funeral Homes P. 1630 Edmondson Avenue, Catonsville, Md. 21228</b>  |  |  |  | 25. DATE RECEIVED BY REGISTRAR<br><b>JAN 10 1985</b>  |  |  |  |

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STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

85 01614

REG. NO.

|  |  |   |   |  |                                       |   |  |  |  |   |  |
|--|--|---|---|--|---------------------------------------|---|--|--|--|---|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>FIRST MIDDLE LAST<br><b>CHARLES L. THOMAS</b>   |  |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>1 7 85</b>                  |  | 2b. HOUR<br><b>10<sup>45</sup> AM</b> |   |  |  |  |   |  |
| 3. SEX<br><b>MALE</b>  |  | 4. RACE<br><b>NEGRO</b>   |   | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>01 04 41</b>  |                                       | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>44 YRS.</b>   |  | 7. IF UNDER 1 YEAR<br>MONTHS DAYS<br><b>44 YRS.</b>              |  | 8. IF UNDER 24 HRS.<br>HOURS MIN.<br><b>44 YRS.</b> |  |
| 9. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Maryland</b>  |  | 10. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>   |   | 11. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |                                       | 12. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore City, MD.</b>                             |  |  |  |   |  |
| 13. CITY OR TOWN OF DEATH<br><b>BALTO</b>  |  | 14. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>FARMER SCOTNEY HOSPITAL</b> |   |  |                                       | 15. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>POSTMAN</b>               |  |  |  | 16. KIND OF BUSINESS OR INDUSTRY                    |  |
| 17. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>17a. STATE<br><b>Maryland</b> |  | 17b. COUNTY<br><b>Baltimore</b>   |   | 17c. CITY OR TOWN<br><b>Baltimore</b>  |                                       | 17d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 17e. STREET ADDRESS / ZIP CODE<br><b>1833 Winford Road 21239</b> |  |   |  |
| 18. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Charlie Sampson</b>   |  |   | 19. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Lillie Thomas</b> |  |                                       |   |  |  |  |   |  |
| 20. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)<br><b>Yes</b>                |  |   | 21. SOCIAL SECURITY NO.<br><b>218-36-3972</b>                         |  |                                       | 22. INFORMANT ADDRESS<br><b>Earline Thomas 3165 Elmora Avenue</b>                               |  |  |  |   |  |

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).  
PART I. DEATH WAS CAUSED BY:IMMEDIATE CAUSE (a) **CARDIO PULMONARY ARREST**APPROXIMATE INTERVAL  
BETWEEN ONSET AND DEATH**1 HR**Conditions, if any, which  
gave rise to immediate  
cause (a), stating the  
underlying cause lost.

DUE TO, OR AS A CONSEQUENCE OF

(b) **GASTRO INTESTINAL BLEEDING**

DUE TO, OR AS A CONSEQUENCE OF

(c)

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)

|   |  |   |  |  |  |   |  |
|---|--|---|--|--|--|---|--|
| 19a. DATE OF OPERATION<br><b>1/5/85</b>   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED<br><b>Bleeding Gastric Ulcer</b> |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>      |  | 20b. IF YES, WERE FINDINGS USED<br>IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>                 |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 19, PART 1 OR PART 2) |  |   |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)            |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                              |  |   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>1/4/85</b> , 19____, to <b>1/7/85</b> , 19____, that (I) (we) lost<br>saw the deceased alive on <b>1/7/85</b> , 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated<br>above, (I) (we) (did) (did not) view the body after death. |  |   |  |  |  |   |  |
| 22b. SIGNATURE<br><b>J. Naiman</b>  |  |   |  | DEGREE<br><b>MD</b>  |  | 22c. DATE SIGNED<br><b>1/7/85</b>   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>Naiman</b>  |  |   |  | 22e. ADDRESS<br><b>JOHNS HOPKINS HOSPITAL</b>                                  |  |   |  |

|  |  |                             |  |  |  |   |  |
|--|--|-----------------------------|--|--|--|---|--|
| 23a. BURIAL, CREMATION, REMOVAL<br><b>BURIAL</b>                                       |  | 23b. DATE<br><b>1/12/85</b> |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Arbutus Memorial Pk</b> |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Arbutus, Md.</b> |  |
| 24. FUNERAL DIRECTOR<br>NAME ADDRESS<br><b>Wm C March F/H Inc. 1101 E North Avenue</b> |  |                             |  | 25a. DATE REC'D. BY REGISTRAR<br><b>1 JAN 8 1985</b>             |  | 25b. REGISTRAR'S SIGNATURE<br><b>She Davidson-Randall</b>         |  |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 7 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, this page should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 24 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH   |  |  |  |  | REG. NO.   |  |
|--|--|--|--|--|--|--|
| 1. FOR STATE REGISTRAR   |  |  |  |  |  |  |
| 1 DECEASED NAME (TYPE OR PRINT)<br>FIRST MIDDLE LAST<br>Charles Wesley Thomas  |  |  |  |  | 2a DATE OF DEATH MONTH DAY YEAR<br>January 2, 1985 |  |
| 3 SEX<br>Male  |  | 4 RACE<br>Black  |  | 5. DATE OF BIRTH MONTH DAY YEAR<br>8 9 02  |  |  |
| 6. AGE (IN YEARS LAST BIRTHDAY)<br>83 YRS.   |  | IF UNDER 1 YEAR<br>MONTHS DAYS   |  | IF UNDER 24 HRS<br>HOURS MIN.  |  |  |
| 7a BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Balto. Md.   |  | 7b. CITIZEN OF WHAT COUNTRY?<br>USA  |  | 8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> |  |  |
| 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Baltimore City MD.   |  | 10 CITY OR TOWN OF DEATH<br>Baltimore  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>1720 Edmondson Avenue                            |  |  |
| 12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)   |  | 12b KIND OF BUSINESS OR INDUSTRY   |  |  |  |  |
| 13a. STATE<br>MD   |  | 13b. COUNTY  |  | 13c. CITY OR TOWN<br>Baltimore   |  |  |
| 14 FATHER'S NAME FIRST MIDDLE LAST<br>George A. Thomas   |  | 15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST<br>Serena Thomas   |  | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>   |  |  |
| 16a WAS DECEASED EVER IN U.S. ARMED FORCES? (NO OR UNKNOWN) No   |  | 16b. SOCIAL SECURITY NO.   |  | 17 INFORMANT ADDRESS<br>Beverly Salvant 7832 W. Collingham Dr. 21222   |  |  |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>RESPIRATORY ARREST</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <u>EMPHYSEMA</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. |  |  |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH       |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: _____   |  |  |  |  |  |  |
| 19a DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>   |  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)  |  |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK   |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE<br>1/2/85   |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from 8/4/84 19, to 1/2/85 19, that (I) (we) lost the deceased alive on 12/13/84 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.  |  |  |  |  |  |  |
| 22b. SIGNATURE<br>Winthrop C. Davis, MD  |  | DEGREE<br>ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |  | 22c. DATE SIGNED<br>1/2/85   |  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>WINTHROP C. DAVIS, MD   |  | 22e. ADDRESS<br>700 WASHINGTON BLVD  |  |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br>Cremation   |  | 23b. DATE<br>1/3/85  |  | 23c. NAME OF CEMETERY OR CREMATORY<br>Westview Mem. Pk.  |  |  |
| 23d. LOCATION<br>Balto. Co. MD   |  | 23e. STATE   |  |  |  |  |
| 24 FUNERAL DIRECTOR NAME<br>Wm. C. March F/H   |  | ADDRESS<br>1101 E. North Ave.  |  | 25a. DATE REC'D. BY REGISTRAR<br>JAN 3 1985  |  |  |
| 25b. REGISTRAR'S SIGNATURE<br>Julia Davidson-Randall   |  |  |  |  |  |  |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, Page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Page 4 and 2 would be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

85 01616

1- FOR  
STATE  
REGISTRAR

REG. NO.

|   |  |   |   |   |  |   |  |  |  |
|---|--|---|---|---|--|---|--|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br><b>CLAUDE THOMAS Jr.</b>   |  |   | 7a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>1-26-85</b>   |   |  | 7b. HOUR<br><b>12:15 P<sup>M</sup></b>                            |  |  |  |
| 3 SEX<br><b>Male</b>  |  | 4. RACE<br><b>Black</b>   |   | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>12 24 38</b>   |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>46</b> YRS.                 |  | 8. IF UNDER 1 YEAR<br>MONTHS DAYS HOURS MIN.<br><b>0 0 0 0</b> |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>N.C.</b>  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>  |   | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore City</b> MD. |  |  |  |
| 10. CITY OR TOWN OF DEATH<br><b>Baltimore</b>   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Lutheran Hospital</b> |   |   |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)  |  | 12b. KIND OF BUSINESS OR INDUSTRY                              |  |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)                       |  |   | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |   |  | 13e. STREET ADDRESS / ZIP CODE<br><b>1149 N. Mount St. 21217</b>  |  |  |  |
| 13a. STATE<br><b>MD</b>   |  | 13b. COUNTY   |   | 13c. CITY OR TOWN<br><b>Baltimore</b>   |  |   |  |  |  |
| FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Claude Thomas Sr.</b>  |  |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Mable McKeithan</b>                         |   |  |   |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)<br><b>No</b> |  | 16b. SOCIAL SECURITY NO.<br><b>243-50-9795</b>  |   | 17. INFORMANT <b>Marie</b> ADDRESS<br><b>Pearl M. Thomas 1149 N. Mount St.</b>  |  |   |  |  |  |

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).  
PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a)

**ANoxic Encephalopathy**

DUE TO, OR AS A CONSEQUENCE OF

(b)

**Cardiopulmonary arrest**

DUE TO, OR AS A CONSEQUENCE OF

(c)

**Acute MI**APPROXIMATE INTERVAL  
BETWEEN ONSET AND DEATH

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a

MEDICAL CERTIFICATION

|   |  |  |  |  |  |   |  |
|---|--|--|--|--|--|---|--|
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                       |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  | 20b. IF YES, WERE FINDINGS USED<br>IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19             |  | 21c. HOW INJURY OCCURRED<br>(ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)    |  |   |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                    |  |   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>1-21-85</b> 19 <b>85</b> , to <b>1-26</b> 19 <b>85</b> , that (I) (we) last saw the deceased alive on <b>1-26</b> 19 <b>85</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |  |  |  |  |  |   |  |
| 27b. SIGNATURE<br><b>BICH T DUONG</b>   |  |  |  | DEGREE<br><b>M.D.</b>  |  | 27c. DATE SIGNED<br><b>1-26-85</b>  |  |
| 27d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>BICH T DUONG</b>  |  |  |  | 27e. ADDRESS<br><b>LUTHERAN HOSPITAL</b>   |  |   |  |

|   |  |                            |  |   |  |   |  |
|---|--|----------------------------|--|---|--|---|--|
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>Burial</b> |  | 23b. DATE<br><b>2/1/85</b> |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Baltimore Cem.</b> |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Baltimore MD</b> |  |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>Wm. C. March F/H</b>       |  |                            |  | ADDRESS<br><b>1101 E. North Ave.</b>                        |  | 25a. DATE REC'D. BY REGISTRAR<br><b>JAN 28 1985</b>               |  |
|   |  |                            |  | 25b. REGISTRAR'S SIGNATURE<br><b>[Signature]</b>            |  |   |  |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|  |  |   |  |   |   |  |  |   |  |
|--|--|---|--|---|---|--|--|---|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>Matthew Tyrone Thomas</b>   |  |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>1 18 85</b>                  |   |   | 2b. HOUR<br><b>8:24P<sup>M</sup></b>   |  |   |  |
| 3. SEX<br><b>Male</b>  |  | 4. RACE<br><b>Black</b>   |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>3 20 1960</b>  |   | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>24</b>   |  | IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS.<br>HOURS MIN.  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Balto., Md.</b>  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>   |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>City</b> MD.  |  |   |  |
| 10. CITY OR TOWN OF DEATH<br><b>Balto</b>  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>FRANCIS SCOTT KEY</b> |  |   |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Laborer</b>   |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>Md. Paint</b>   |  |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)  |  |   |  |   | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |  |   |  |
| 13a. STATE<br><b>Md.</b>   |  | 13b. COUNTY   |  | 13c. CITY OR TOWN<br><b>Balto</b>   |   | 13e. STREET ADDRESS / ZIP CODE<br><b>1215 W. Saratoga ST. 21223</b>  |  |   |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>William Jones</b>   |  |   |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Dorothy Falcon</b>  |   |  |  |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>No</b>  |  |   |  | 16b. SOCIAL SECURITY NO.<br><b>213-76-9114</b>  |   | 17. INFORMANT ADDRESS<br><b>Mrs. Paula M. Thomas 1215 W. Saratoga</b>  |  |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>cardiac arrest</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <b>arrhythmia</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <b>Cardiomyopathy</b>   |  |   |  |   |   |  |  | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH   |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)  |  |   |  |   |   |  |  |   |  |
| 19a. DATE OF OPERATION   |  |   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                       |   |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>  |  | 20b. IF YES, WERE FINDINGS USED<br>IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER NOTIFY MEDICAL EXAMINER)  |  |   | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19             |   |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)   |  |   |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>   |  |   | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) |   |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE  |  |   |  |
| 22a. I certify that (I [he this hospital] attended the deceased from <b>4/7</b> , 19 <b>85</b> , to <b>1/18</b> , 19 <b>85</b> , that (I) (we) last saw the deceased alive on <b>1/18</b> , 19 <b>85</b> , and that in my (our) opinion death occurred on the date and hour and from the causes stated above (I [we] did not) view the body after death. |  |   |  |   |   |  |  |   |  |
| 22b. SIGNATURE<br><b>Charles B. Treasure</b>   |  |   | DEGREE<br><b>MD</b>  |   |   | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> |  | 22c. DATE SIGNED<br><b>1/18/85</b>  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>Charles B. Treasure</b>  |  |   | 22e. ADDRESS<br><b>Francis Scott Key Med Center Balto, MD</b>          |   |   |  |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>Burial</b>  |  |   | 23b. DATE<br><b>1-22-85</b>  |   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Eastview</b>   |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Balto Balto Md.</b> |   |  |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>James A. Morton &amp; Sons F.H. 1701 Laurens Street</b>   |  |   |  |   |   | 25a. DATE REC'D. BY REGISTRAR<br><b>62 1985</b>  |  | 25b. REGISTRAR'S SIGNATURE<br><b>Jeha Davidson-Hendall</b>  |  |

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STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8-5 01618

1- FOR  
STATE  
REGISTRAR

REG. NO.

|  |  |   |   |   |   |
|--|--|---|---|---|---|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br><b>PAUL A. THOMAS</b>                       |  |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>1 4 85</b>  |   | 2b. HOUR<br><b>9:45P M</b>                              |
| 3. SEX<br><b>MALE</b>  | 4. RACE<br><b>CAUCASIAN</b>  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>3 9 18</b>   |   | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>66</b> YRS.                       | # UNDER 1 YEAR<br>MONTHS DAYS<br><b>0 0</b>             |
| 7. BIRTHPLACE<br>(COUNTRY)<br><b>Pennsylvania</b>                                  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>   | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>BALTIMORE CITY</b> MD                                |   |   |
| 10. CITY OR TOWN OF DEATH<br><b>BALTIMORE</b>                                      | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>SOUTH BALTIMORE General Hospital</b> |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>RIGGER FOREMAN</b>       |   | 12b. KIND OF BUSINESS OR<br>INDUSTRY<br><b>DRY DOCK</b> |
| 13a. STATE<br><b>MARYLAND</b>  | 13b. COUNTY<br><b>ANNE ARUNDEL</b>   | 13c. CITY OR TOWN<br><b>GLEN BURNIE</b>   | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 13e. STREET ADDRESS / ZIP CODE<br><b>411 BUENWOOD AVE 21061</b>         |   |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>GRANT THOMAS</b>                      |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>ORPHA RHUBRIGHT</b>   |   |   |   |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>YES</b> | (IF YES, GIVE WAR OR DATES)<br><b>WW II</b>  | 16b. SOCIAL SECURITY NO.<br><b>170-018019</b>   |   | 17. INFORMANT<br>ADDRESS<br><b>GARIBOLD F. THOMAS F.H. SAUSBURY, PA</b> |   |

|   |  |   |
|---|--|---|
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>CARDIO PULMONARY ARREST</b> |  | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH |
| DUE TO, OR AS A CONSEQUENCE OF<br>(b) <b>COP. D. &amp; ASCVD.</b>   |  |   |
| DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____   |  |   |

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: \_\_\_\_\_

|  |  |  |   |
|--|--|--|---|
| 19a. DATE OF OPERATION   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                       | 20a. AUTOPSY?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | 20b. IF YES, WERE FINDINGS USED<br>IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>      | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)        |   |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK   | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                    |   |
| 22a. I certify that (this hospital) attended the deceased from <b>12-21</b> , 19 <b>84</b> , to <b>1-4</b> , 19 <b>85</b> , that (we) lost<br>saw the deceased alive on <b>1-4</b> , 19 <b>85</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated<br>(above, (b) (we) did) (did not) the body after death. |  |  |   |
| 22b. SIGNATURE<br><b>John D. Milto MD</b>  |  | DEGREE<br><b>MD</b>  | 22c. DATE SIGNED<br><b>1-4-85</b>   |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>JOHN D. MILTO MD</b>   |  | 22e. ADDRESS<br><b>3001 S. HANOVER ST</b>  |   |

|   |                            |   |   |
|---|----------------------------|---|---|
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>Rem.-Burial</b>                          | 23b. DATE<br><b>1-8-85</b> | 23c. NAME OF CEMETERY OR CREMATORY<br><b>St. Paul</b> | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Elk Lick Township Somerset Pa.</b> |
| 24. FUNERAL DIRECTOR<br>NAME ADDRESS<br><b>Henry W. Jenkins &amp; Sons Co., Balto., Md.</b> |                            | 25a. DATE REC'D. BY REGISTRAR<br><b>JAN 7 1985</b>    |   |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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IMPORTANT: If item 21 is marked at item 18 shows any injury or other traumatic event, the medical examiner must be notified at once.

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Pat. 1911 1-3-32

Henry W. Loring & Son Co., Boston.

JAN 2

Ed. Lick Township



TO HOSPITAL OR ATTENDING PHYSICIAN. The law requires that the death certificate be executed within 24 hours after death. It may be obtained by the hospital or attending physician.

TO FUNERAL DIRECTOR. After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon-papers. Pages 1, 2, 3, 4, 5, 6, 7, 8, 9, 10, 11, 12, 13, 14, 15, 16, 17, 18, 19, 20, 21, 22, 23, 24, 25, 26, 27, 28, 29, 30, 31, 32, 33, 34, 35, 36, 37, 38, 39, 40, 41, 42, 43, 44, 45, 46, 47, 48, 49, 50, 51, 52, 53, 54, 55, 56, 57, 58, 59, 60, 61, 62, 63, 64, 65, 66, 67, 68, 69, 70, 71, 72, 73, 74, 75, 76, 77, 78, 79, 80, 81, 82, 83, 84, 85, 86, 87, 88, 89, 90, 91, 92, 93, 94, 95, 96, 97, 98, 99, 100, 101, 102, 103, 104, 105, 106, 107, 108, 109, 110, 111, 112, 113, 114, 115, 116, 117, 118, 119, 120, 121, 122, 123, 124, 125, 126, 127, 128, 129, 130, 131, 132, 133, 134, 135, 136, 137, 138, 139, 140, 141, 142, 143, 144, 145, 146, 147, 148, 149, 150, 151, 152, 153, 154, 155, 156, 157, 158, 159, 160, 161, 162, 163, 164, 165, 166, 167, 168, 169, 170, 171, 172, 173, 174, 175, 176, 177, 178, 179, 180, 181, 182, 183, 184, 185, 186, 187, 188, 189, 190, 191, 192, 193, 194, 195, 196, 197, 198, 199, 200, 201, 202, 203, 204, 205, 206, 207, 208, 209, 210, 211, 212, 213, 214, 215, 216, 217, 218, 219, 220, 221, 222, 223, 224, 225, 226, 227, 228, 229, 230, 231, 232, 233, 234, 235, 236, 237, 238, 239, 240, 241, 242, 243, 244, 245, 246, 247, 248, 249, 250, 251, 252, 253, 254, 255, 256, 257, 258, 259, 260, 261, 262, 263, 264, 265, 266, 267, 268, 269, 270, 271, 272, 273, 274, 275, 276, 277, 278, 279, 280, 281, 282, 283, 284, 285, 286, 287, 288, 289, 290, 291, 292, 293, 294, 295, 296, 297, 298, 299, 300, 301, 302, 303, 304, 305, 306, 307, 308, 309, 310, 311, 312, 313, 314, 315, 316, 317, 318, 319, 320, 321, 322, 323, 324, 325, 326, 327, 328, 329, 330, 331, 332, 333, 334, 335, 336, 337, 338, 339, 340, 341, 342, 343, 344, 345, 346, 347, 348, 349, 350, 351, 352, 353, 354, 355, 356, 357, 358, 359, 360, 361, 362, 363, 364, 365, 366, 367, 368, 369, 370, 371, 372, 373, 374, 375, 376, 377, 378, 379, 380, 381, 382, 383, 384, 385, 386, 387, 388, 389, 390, 391, 392, 393, 394, 395, 396, 397, 398, 399, 400, 401, 402, 403, 404, 405, 406, 407, 408, 409, 410, 411, 412, 413, 414, 415, 416, 417, 418, 419, 420, 421, 422, 423, 424, 425, 426, 427, 428, 429, 430, 431, 432, 433, 434, 435, 436, 437, 438, 439, 440, 441, 442, 443, 444, 445, 446, 447, 448, 449, 450, 451, 452, 453, 454, 455, 456, 457, 458, 459, 460, 461, 462, 463, 464, 465, 466, 467, 468, 469, 470, 471, 472, 473, 474, 475, 476, 477, 478, 479, 480, 481, 482, 483, 484, 485, 486, 487, 488, 489, 490, 491, 492, 493, 494, 495, 496, 497, 498, 499, 500, 501, 502, 503, 504, 505, 506, 507, 508, 509, 510, 511, 512, 513, 514, 515, 516, 517, 518, 519, 520, 521, 522, 523, 524, 525, 526, 527, 528, 529, 530, 531, 532, 533, 534, 535, 536, 537, 538, 539, 540, 541, 542, 543, 544, 545, 546, 547, 548, 549, 550, 551, 552, 553, 554, 555, 556, 557, 558, 559, 560, 561, 562, 563, 564, 565, 566, 567, 568, 569, 570, 571, 572, 573, 574, 575, 576, 577, 578, 579, 580, 581, 582, 583, 584, 585, 586, 587, 588, 589, 590, 591, 592, 593, 594, 595, 596, 597, 598, 599, 600, 601, 602, 603, 604, 605, 606, 607, 608, 609, 610, 611, 612, 613, 614, 615, 616, 617, 618, 619, 620, 621, 622, 623, 624, 625, 626, 627, 628, 629, 630, 631, 632, 633, 634, 635, 636, 637, 638, 639, 640, 641, 642, 643, 644, 645, 646, 647, 648, 649, 650, 651, 652, 653, 654, 655, 656, 657, 658, 659, 660, 661, 662, 663, 664, 665, 666, 667, 668, 669, 670, 671, 672, 673, 674, 675, 676, 677, 678, 679, 680, 681, 682, 683, 684, 685, 686, 687, 688, 689, 690, 691, 692, 693, 694, 695, 696, 697, 698, 699, 700, 701, 702, 703, 704, 705, 706, 707, 708, 709, 710, 711, 712, 713, 714, 715, 716, 717, 718, 719, 720, 721, 722, 723, 724, 725, 726, 727, 728, 729, 730, 731, 732, 733, 734, 735, 736, 737, 738, 739, 740, 741, 742, 743, 744, 745, 746, 747, 748, 749, 750, 751, 752, 753, 754, 755, 756, 757, 758, 759, 760, 761, 762, 763, 764, 765, 766, 767, 768, 769, 770, 771, 772, 773, 774, 775, 776, 777, 778, 779, 780, 781, 782, 783, 784, 785, 786, 787, 788, 789, 790, 791, 792, 793, 794, 795, 796, 797, 798, 799, 800, 801, 802, 803, 804, 805, 806, 807, 808, 809, 810, 811, 812, 813, 814, 815, 816, 817, 818, 819, 820, 821, 822, 82

RELEASED AS NON-MED DR DIXON PER MR LAWYER

## MEDICAL CERTIFICATION

FOR  
STATE  
REGISTRAR

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|   |  |  |  |   |  |   |  |  |  |  |  |
|---|--|--|--|---|--|---|--|--|--|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)   |  | FIRST MIDDLE LAST  |  | 2a. DATE OF DEATH   |  | MONTH YEAR  |  | 2b. HOUR   |  | P M  |  |
| ROY   |  | C.   |  | THOMAS  |  | JANUARY 18, 1985  |  | 8:18   |  | P M  |  |
| 3. SEX  |  | 4. RACE  |  | 5. DATE OF BIRTH  |  | 6. AGE (IN YEARS LAST BIRTHDAY)                                     |  | 7. IF UNDER 1 YEAR   |  | 7b. IF UNDER 24 HRS                          |  |
| Male  |  | Black  |  | MONTH DAY YEAR<br>8 10 40   |  | 44 YRS.   |  | MONTHS DAYS  |  | HOURS MIN.                                   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)   |  | 7b. CITIZEN OF WHAT COUNTRY?   |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH                                |  |  |  |  |  |
| N. Carolina   |  | U.S.A.   |  |   |  | BALTIMORE CITY MD   |  |  |  |  |  |
| 10. CITY OR TOWN OF DEATH   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) |  |   |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)       |  | 12b. KIND OF BUSINESS OR INDUSTRY                              |  |  |  |
| BALTIMORE   |  | JOHNS HOPKINS HOSPITAL   |  |   |  |   |  |  |  |  |  |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)   |  |  |  |   |  |   |  |  |  |  |  |
| 13a. STATE  |  | 13b. COUNTY  |  | 13c. CITY OR TOWN   |  | 13d. INSIDE CITY LIMITS?  |  | 13e. STREET ADDRESS / ZIP CODE                                 |  |  |  |
| Maryland  |  |  |  | Baltimore   |  | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 936 N. Eden St. 21205  |  |  |  |
| 14. FATHER'S NAME   |  |  |  |   |  | 15. MOTHER'S MAIDEN NAME  |  |  |  |  |  |
| FIRST MIDDLE LAST   |  |  |  |   |  | FIRST MIDDLE LAST   |  |  |  |  |  |
| James C. Thomas   |  |  |  |   |  | Lois Wiley  |  |  |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)   |  |  |  | 16b. SOCIAL SECURITY NO.  |  | 17. INFORMANT ADDRESS   |  |  |  |  |  |
| YES   |  |  |  | 216-42-0338   |  | Jeanette D. Thomas 936 N. Eden St.                                  |  |  |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY:   |  |  |  |   |  |   |  |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |  |
| IMMEDIATE CAUSE (a) Cardiac arrest  |  |  |  |   |  |   |  |  |  | 2 min  |  |
| DUE TO, OR AS A CONSEQUENCE OF (b) Exsanguination, hemorrhage   |  |  |  |   |  |   |  |  |  | 3 h  |  |
| DUE TO, OR AS A CONSEQUENCE OF (c)  |  |  |  |   |  |   |  |  |  |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a  |  |  |  |   |  |   |  |  |  |  |  |
| Alcoholism  |  |  |  |   |  |   |  |  |  |  |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  |   |  | 20a. AUTOPSY?   |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? |  |  |  |
| 1/18/85   |  | Bleeding varice  |  |   |  | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  | YES <input type="checkbox"/> NO <input type="checkbox"/>       |  |  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |  |   |  |  |  |  |  |
|   |  | HOUR A.M. MONTH DAY YEAR   |  |   |  |   |  |  |  |  |  |
|   |  | P.M. 19  |  |   |  |   |  |  |  |  |  |
| 21d. INJURY OCCURRED  |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                                    |  | 21f. LOCATION   |  |   |  |  |  |  |  |
| WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK   |  |  |  | STREET CITY OR TOWN COUNTY STATE  |  |   |  |  |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from 1/18 19 85 to 1/18 19 85 that (I) (we) lost  |  |  |  |   |  |   |  |  |  |  |  |
| saw the deceased alive on 1/18 19 85 and that in my (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) did (did not) view the body after death. |  |  |  |   |  |   |  |  |  |  |  |
| 22b. SIGNATURE  |  |  |  |   |  |   |  |  |  | 22c. DATE SIGNED                             |  |
| Eric A. Wiebke MD   |  |  |  |   |  |   |  |  |  | 1/18/85                                      |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)   |  |  |  |   |  |   |  |  |  | 22e. ADDRESS                                 |  |
| ERIC A. WIEBKE  |  |  |  |   |  |   |  |  |  | JOHNS HOPKINS HOSPITAL                       |  |
| 23a. BURIAL, CREMATION, REMOVAL   |  | 23b. DATE  |  | 23c. NAME OF CEMETERY OR CREMATORY  |  | 23d. LOCATION   |  |  |  |  |  |
| BURIAL  |  | 1/23/85  |  | Md. Veteran Cem.  |  | Crownsville, COUNTY STATE   |  | Md.  |  |  |  |
| 24. FUNERAL DIRECTOR  |  |  |  |   |  | 25a. DATE REC'D. BY REGISTRAR                                       |  | 25b. REGISTRAR'S SIGNATURE                                     |  |  |  |
| NAME ADDRESS  |  |  |  |   |  | JAN 21 1985   |  | Eric A. Wiebke   |  |  |  |
| Wm C March F/H Inc. 1101 E North Avenue   |  |  |  |   |  |   |  |  |  |  |  |

CHIEF WAX  
13117  
10100 2002

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

85 01620

|  |  |   |  |
|--|--|---|--|
| FOR<br>STATE<br>REGISTRAR  |  | REG. NO.  |  |
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>FIRST MIDDLE LAST<br>TAMMY J. THOMAS  |  | 2a. DATE OF DEATH MONTH DAY YEAR<br>JANUARY 15 85   |  |
| 3. SEX<br>Female   |  | 2b. HOUR<br>4:47 M  |  |
| 4. RACE<br>Caucasian   |  | 5. DATE OF BIRTH MONTH DAY YEAR<br>Dec 3, 1969  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Md.   |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br>15 YRS.  |  |
| 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.A.   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  |
| 10. CITY OR TOWN OF DEATH<br>BALTIMORE   |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>BALTIMORE CITY MD.  |  |
| 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>F.S. KEY MEDICAL CENTER   |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>N.A.  |  |
| 13a. STATE<br>MD   |  | 12b. KIND OF BUSINESS OR INDUSTRY<br>N.A.   |  |
| 13b. COUNTY  |  | 13c. CITY OR TOWN<br>BALTO.   |  |
| 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>  |  | 13e. STREET ADDRESS<br>305 Bay 115 Street   |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>CARROLL H. THOMAS  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>BETTY CARR   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br>NO   |  | 16b. SOCIAL SECURITY NO.<br>215-88-2804   |  |
| 17. INFORMANT<br>Robert E. Jones   |  | ADDRESS<br>305 Bay 115 St.<br>BALTO. MD. 21224  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) CARDIOPULMONARY ARREST<br>DUE TO, OR AS A CONSEQUENCE OF HISTORY OF CONGENITAL HEART<br>(b) DISEASE AND MITRAL VALVE PROSTHETIC REPLACEMENT<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) |  |   |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a   |  |   |  |
| MEDICAL CERTIFICATION  |  |   |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  |
| 20a. AUTOPSY?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>   |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                       |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK   |  | 21e. PLACE OF INJURY<br>(AT HOME STREET, FACTORY, OFFICE, FARM, ETC.)   |  |
| 21f. INJURY OCCURRED   |  | 21i. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |
| 22a. I certify that (I (this hospital) attended the deceased from 1/15, 1985, to 1/15, 1985, that (I) (we) lost saw the deceased alive on 1/15, 1985, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.       |  |   |  |
| 22b. SIGNATURE<br>D. Brandes   |  | 22c. DATE SIGNED<br>1/16/85   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>D. BRANDES  |  | 22e. ADDRESS<br>4940 EASTERN AV. - BALTO. MD. 21224   |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br>Burial   |  | 23b. DATE<br>1-19-1985  |  |
| 23c. NAME OF CEMETERY OR CREMATORY<br>Cedar Hill Cemetery  |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>BALTO. MD.  |  |
| 24. FUNERAL DIRECTOR<br>NAME<br>Joseph N. Zannino Jr.  |  | 25a. DATE REC'D. BY REGISTRAR<br>JAN 18 1985  |  |
| 25b. REGISTRAR'S SIGNATURE<br>[Signature]  |  |   |  |

Page 4 may be retained by the hospital or attending physician. The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be filed within 72 hours after death. Pages 3 and 4 should be filed within 72 hours after death. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

16

(2)

TO THE HONORABLE SECRETARY OF AGRICULTURE

WASHINGTON, D. C.

FROM THE DIRECTOR OF THE BUREAU OF PLANT INDUSTRY

SUBJECT: [Illegible]

RE: [Illegible]

DATE: [Illegible]

REFERENCE: [Illegible]

1. [Illegible]

2. [Illegible]

3. [Illegible]

4. [Illegible]

5. [Illegible]

6. [Illegible]

7. [Illegible]

8. [Illegible]

9. [Illegible]

10. [Illegible]

11. [Illegible]

12. [Illegible]

13. [Illegible]

14. [Illegible]

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

85

01621

1. FOR  
STATE  
REGISTRAR

REG. NO.

|   |  |   |  |   |  |  |  |   |  |   |  |
|---|--|---|--|---|--|--|--|---|--|---|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>FIRST MIDDLE LAST<br>William U. Thomas Sr  |  |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br>1 4 85                          |   | 2b. HOUR<br>6 <sup>10</sup> M                          |  |  |   |  |   |  |
| 1. SEX<br>Male  |  | 4. RACE<br>Black  |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>10 23 16  |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br>68 YRS.                                     |  | 7. IF UNDER 1 YEAR<br>MONTHS DAYS   |  | 8. IF UNDER 24 HRS.<br>HOURS MIN.                           |  |
| 9. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Fla.  |  | 7b. CITIZEN OF WHAT COUNTRY?<br>USA   |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Baltimore City MD.                     |  |   |  |   |  |
| 10. CITY OR TOWN OF DEATH<br>Baltimore  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>Saint Agnes Hospital |  |   |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)               |  | 12b. KIND OF BUSINESS OR INDUSTRY   |  |   |  |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE<br>MD  |  |   |  | 13b. COUNTY<br>Baltimore  |  | 13c. CITY OR TOWN<br>Elkridge  |  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                                 |  | 13e. STREET ADDRESS / ZIP CODE<br>7169 Montgomery Rd. 21227 |  |
| 14. FATHER'S NAME<br>(FIRST MIDDLE LAST)<br>William Thomas  |  |   |  | 15. MOTHER'S MAIDEN NAME<br>(FIRST MIDDLE LAST)<br>Laura  |  |  |  |   |  |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br>Yes   |  | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br>261-09-2345  |  | 17. INFORMANT<br>ADDRESS<br>Donnavia E. Thomas 7169 Montgomery Rd.  |  |  |  |   |  |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) Dehydration / Sepsis<br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) Bladder CARCINOMA<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c)  |  |   |  |   |  |  |  |   |  | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH             |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)   |  |   |  |   |  |  |  |   |  |   |  |
| 19a. DATE OF OPERATION  |  |   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                       |   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>      |  | 20b. IF YES, WERE FINDINGS USED<br>IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>   |  |   |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  |   | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19             |   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) |  |   |  |   |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK   |  |   | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) |   |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                              |  |   |  |   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from 1/4 1985, to 1/4 1985, that (I) (we) last saw the deceased alive on 1/4 1985, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. |  |   |  |   |  |  |  |   |  |   |  |
| 22b. SIGNATURE<br>John Plavery MD   |  |   |  |   |  | DEGREE<br>MD   |  | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |  | 22c. DATE SIGNED<br>1/8/85                                  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>JOHN PLAVEY  |  |   |  |   |  | 22e. ADDRESS<br>St Agnes Hospital Baltimore, MD                                |  |   |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br>Burial  |  |   | 23b. DATE<br>1/8/85  |   | 23c. NAME OF CEMETERY OR CREMATORY<br>Md. Veteran Cem. |  |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Crownsville MD  |  |   |  |
| 24. FUNERAL DIRECTOR<br>NAME<br>Wm. C. March F/H 1101 E. North Ave.   |  |   |  |   |  | 25a. DATE REC'D. BY REGISTRAR<br>JAN 7 1985                                    |  | 25b. REGISTRAR'S SIGNATURE  |  |   |  |

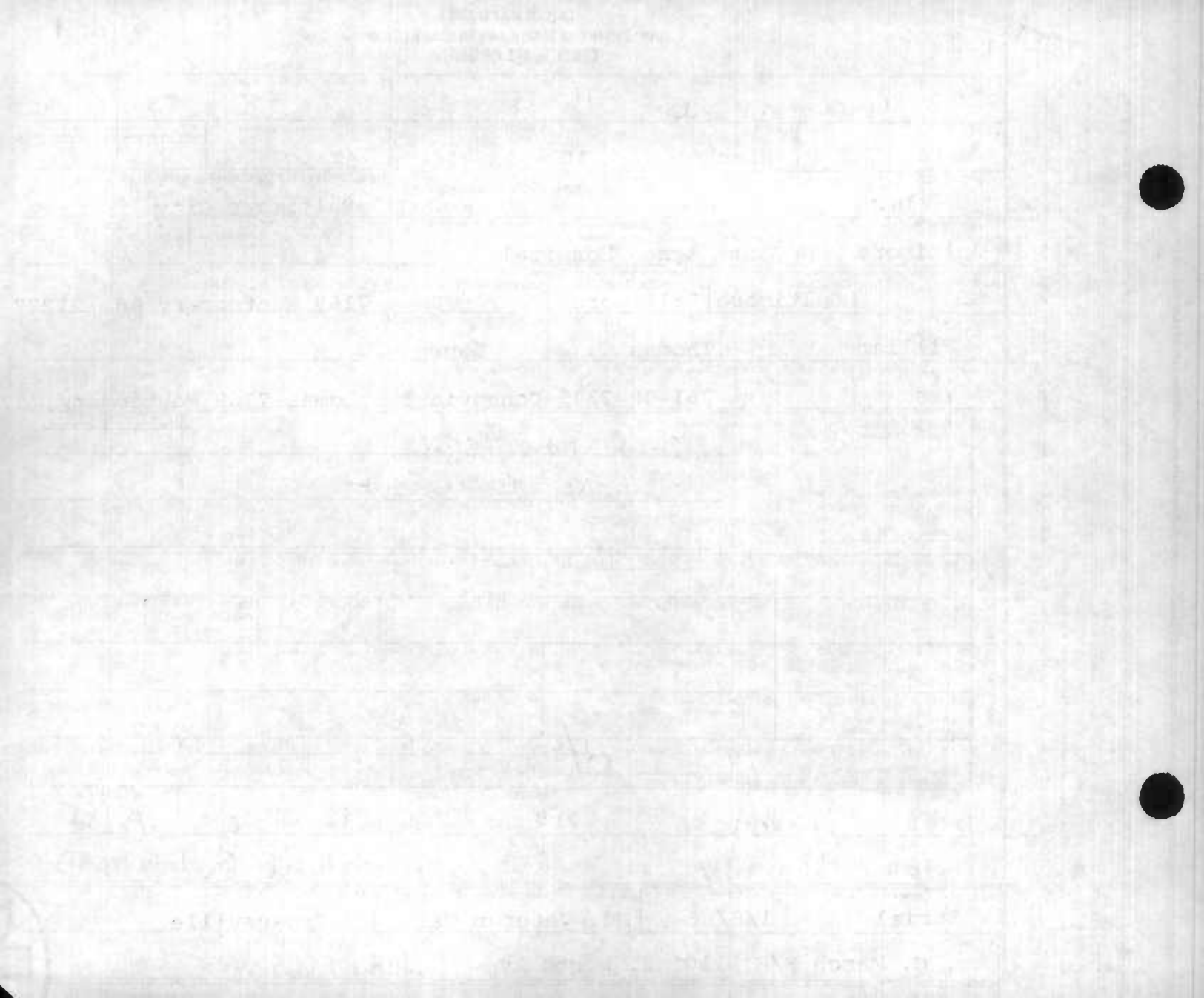
MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 3 and 4 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

BP.





STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

85 01622

FOR  
1. STATE  
REGISTRAR

REG. NO.

|   |  |  |  |   |                   |   |  |  |                                     |  |
|---|--|--|--|---|-------------------|---|--|--|-------------------------------------|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>FIRST MIDDLE LAST<br><i>Thompson Baby Boy</i>  |  |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><i>Jan 7 1985</i> |   |                   | 2b. HOUR<br>M<br><i>7P</i>  |  |  |                                     |  |
| 3. SEX<br><i>Male</i>   |  | 4. RACE<br><i>Black</i>  |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><i>1 7 85</i>   |                   | 6. AGE (IN YEARS LAST BIRTHDAY)<br>YRS.<br><i>3</i>                           |  | IF UNDER 24 HRS<br>HOURS MIN.<br><i>20</i>   |                                     |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><i>Maryland</i>  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><i>USA</i>   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |                   | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><i>Baltimore City</i> MD.             |  |  |                                     |  |
| 10. CITY OR TOWN OF DEATH   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><i>Mercy Hospital</i> |  |   |                   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><i>NA</i> |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><i>NA</i>   |                                     |  |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE   |  |  | 13b. COUNTY  |   | 13c. CITY OR TOWN |   | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  | 13e. STREET ADDRESS<br><i>00000</i> |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><i>Jasper Thompson</i>  |  |  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST   |                   |   |  |  |                                     |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)  |  |  |  | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)   |                   | 17. INFORMANT ADDRESS   |  |  |                                     |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <i>Cardiac arrest</i><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <i>Respiratory Failure</i><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(c) <i>Extreme Prematurity</i> |  |  |  |   |                   |   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH   |                                     |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)<br><i>None</i>  |  |  |  |   |                   |   |  |  |                                     |  |
| 19a. DATE OF OPERATION<br><i>None</i>   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED<br><i>N/A</i>   |  |   |                   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>     |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |                                     |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><i>P.M. 19</i>  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |                   |   |  |  |                                     |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |                   |   |  |  |                                     |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <i>1/7</i> 19 <i>85</i> , to <i>1/7</i> 19 <i>85</i> , that (I) (we) last saw the deceased alive on <i>1/7</i> 19 <i>85</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.     |  |  |  |   |                   |   |  |  |                                     |  |
| 22b. SIGNATURE<br><i>Ellen A. Spurrier MD</i>   |  |  |  | DEGREE<br>ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>        |                   |   |  | 22c. DATE SIGNED<br><i>1/7/85</i>  |                                     |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><i>Ellen A. Spurrier</i>   |  |  |  | 22e. ADDRESS<br><i>University of Maryland Hosp Dept Peds.</i>   |                   |   |  |  |                                     |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><i>Removal</i>  |  | 23b. DATE<br><i>1/10/85</i>  |  | 23c. NAME OF CEMETERY OR CREMATORY  |                   | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE                                    |  |  |                                     |  |
| 24. FUNERAL DIRECTOR<br>NAME<br><i>Anatomy Board</i>  |  |  |  | ADDRESS<br><i>Balto., Md.</i>   |                   | 25a. DATE REC'D. BY REGISTRAR<br><i>JAN 17 1985</i>                           |  | 25b. REGISTRAR'S SIGNATURE<br><i>Lidia Tzavara-Rodriguez</i>   |                                     |  |

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MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be returned by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP



11/11/82  
11/11/82  
11/11/82

|                |      |    |      |    |      |    |      |    |      |
|----------------|------|----|------|----|------|----|------|----|------|
| 79             | 1979 | 79 | 1979 | 79 | 1979 | 79 | 1979 | 79 | 1979 |
| 3-20           |      |    |      |    |      |    |      |    |      |
| Baltimore City |      |    |      |    |      |    |      |    |      |
| NA             |      |    |      |    |      |    |      |    |      |
| NA             |      |    |      |    |      |    |      |    |      |

Thompson  
Black  
USA  
Henry Higgins

Thompson

Charles Street  
Regulatory Failure  
Extreme Prominence

11/11  
11/11

82 1/11

Ellen H. Springer  
University of Maryland  
11/11

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1- FOR  
STATE  
REGISTRAR

|  |   |   |   |   |
|--|---|---|---|---|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br><i>Frances D. Thompson</i>        |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><i>Jan. 3, 1985</i>  |   | 2b. HOUR<br>M   |
| 3. SEX<br><i>Female</i>  | 4. RACE<br><i>White</i>   | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><i>July 28, 1917</i>  |   | 6. AGE (IN YEARS LAST BIRTHDAY)<br>YRS. MONTHS DAYS<br><i>67</i>  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><i>Maryland</i>             | 7b. CITIZEN OF WHAT COUNTRY?<br><i>USA</i>  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><i>Baltimore City</i> MD. |
| 10. CITY OR TOWN OF DEATH<br><i>Baltimore</i>                            | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><i>642 E. Clement St. Balto. Md. 21230</i> |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><i>Housewife</i>                          | 12b. KIND OF BUSINESS OR INDUSTRY                                 |
| 13a. STATE<br><i>Maryland</i>  | 13b. COUNTY<br>-----  | 13c. CITY OR TOWN<br><i>Baltimore</i>   | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>               |   |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><i>John Albert Bergen, Sr.</i> | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><i>Elizabeth --- Betty --- Pett</i>  |   | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)<br><i>No</i> |   |
| 16b. SOCIAL SECURITY NO.<br><i>820-06-2312</i>                           |   | 17. INFORMANT<br>ADDRESS<br><i>Adrienne L. Scally, 2903 Inglewood Ave. Balto. Md.</i>   |   |   |

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)  
PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) *Acute myocardial infarction*

DUE TO, OR AS A CONSEQUENCE OF

Conditions, if any, which  
gave rise to immediate  
cause (a), stating the  
underlying cause last

(b) *Ischemic heart disease*

DUE TO, OR AS A CONSEQUENCE OF

(c)

APPROXIMATE INTERVAL  
BETWEEN ONSET AND DEATH  
*minutes*

*many years*

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: (c)

MEDICAL CERTIFICATION

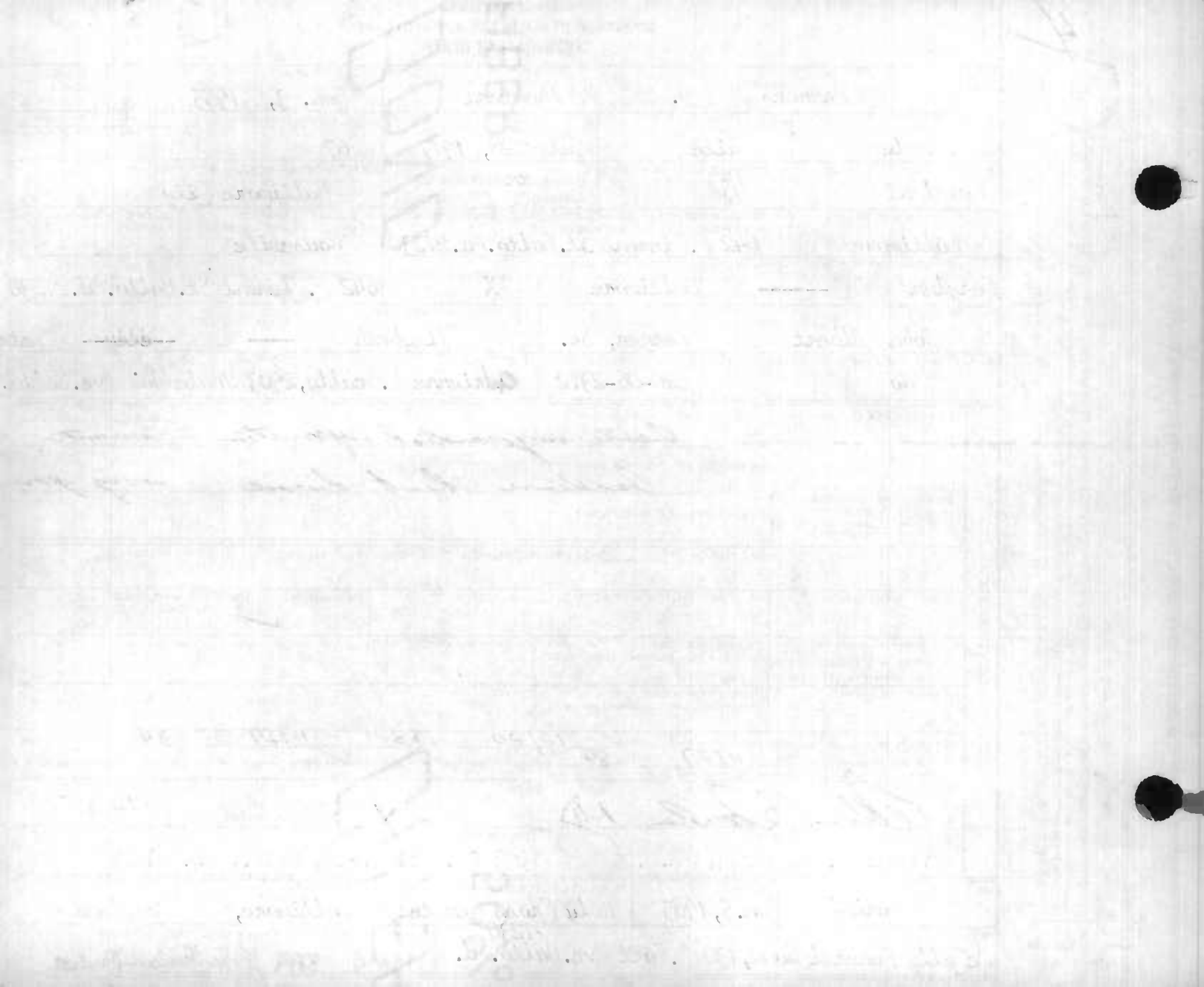
|  |  |  |   |
|--|--|--|---|
| 19a. DATE OF OPERATION   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                       | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 20b. IF YES, WERE FINDINGS USED<br>IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19             | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)       |   |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK   | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                    |   |
| 22a. I certify that (I) (this hospital) attended the deceased from <i>12/20</i> , 19 <i>83</i> , to <i>11/27</i> , 19 <i>84</i> , that (I) (we) lost<br>saw the deceased alive on <i>11/27</i> , 19 <i>84</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated<br>above, (I) (we) (we) (did not) view the body after death. |  |  |   |
| 22b. SIGNATURE<br><i>William B. Davidson</i> MD  |  | 22c. DATE SIGNED<br><i>1/4/85</i>  |   |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><i>William B. Davidson, M.D.</i>  |  | 22e. ADDRESS<br><i>301 St. Paul Place, Balt., MD. 21202</i>                          |   |

|  |                                  |  |  |
|--|----------------------------------|--|--|
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><i>Burial</i>                    | 23b. DATE<br><i>Jan. 5, 1985</i> | 23c. NAME OF CEMETERY OR CREMATORY<br><i>Holy Cross Cemetery</i> | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><i>Baltimore, Maryland</i> |
| 24. FUNERAL DIRECTOR<br><i>McCutty Funeral Home, 130 E. Fort Ave. Balto. Md.</i> |                                  | 25a. DATE REC'D. BY REGISTRAR<br><i>JAN 4 1985</i>               | 25b. REGISTRAR'S SIGNATURE<br><i>Julia Davidson-Randall</i>              |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury or other traumatic event, the medical examiner must be notified at once.



STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 5 0 1 6 2 4

1- FOR  
STATE  
REGISTRAR

REG. NO.

|   |  |  |   |   |   |                                   |                                |
|---|--|--|---|---|---|-----------------------------------|--------------------------------|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br><b>HARVEY THOMPSON</b>   |  |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>1-29-85</b>   |   |   | 2b. HOUR<br><b>4:17 P.M.</b>      |                                |
| 3. SEX<br><b>M</b>  | 4. RACE<br><b>B</b>  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>2 27 07</b> | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>77</b> YRS.   |   | IF UNDER 1 YEAR<br>MONTHS DAYS  |                                   | IF UNDER 24 HRS.<br>HOURS MIN. |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Virginia</b>  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>  |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore City, MD.</b>                              |                                   |                                |
| 10. CITY OR TOWN OF DEATH<br><b>Baltimore</b>   | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Bon Secours Hospital</b> |  |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)        |   | 12b. KIND OF BUSINESS OR INDUSTRY |                                |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE <b>Maryland</b> 13b. COUNTY |  |  | 13c. CITY OR TOWN<br><b>Baltimore</b>   |   | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |                                   |                                |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Alexander Thompson</b>   |  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Ella Johnson</b>  |   |   |                                   |                                |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>YES</b>  |  | 16b. SOCIAL SECURITY NO.<br><b>253-16-2406</b>       |   | 17. INFORMANT<br>ADDRESS<br><b>Brownie Thompson 2011 Penrose Avenue</b> |   |                                   |                                |

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)  
PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) **CARDIAC ARREST**

DUE TO, OR AS A CONSEQUENCE OF

Conditions, if any, which  
gave rise to immediate  
cause (a), stating the  
underlying cause last.

(b) **Congestive + ischemic cardiomyopathy**

DUE TO, OR AS A CONSEQUENCE OF

(c)

APPROXIMATE INTERVAL  
BETWEEN ONSET AND DEATH**Months**

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: (a)

MEDICAL CERTIFICATION

|  |  |  |  |   |   |                                    |
|--|--|--|--|---|---|------------------------------------|
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                       |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>   | 20b. IF YES, WERE FINDINGS USED<br>IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |                                    |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19             |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)  |   |                                    |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |   |                                    |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>1/25</b> , 19 <b>85</b> , to <b>1/29</b> , 19 <b>85</b> , that (I) (we) lost<br>saw the deceased alive on <b>1/25</b> , 19 <b>85</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated<br>above. (I) (we) (did) (did not) view the body after death. |  |  |  |   |   |                                    |
| 22b. SIGNATURE<br><b>Wm C March</b>  |  | DEGREE<br><b>MD</b>  |  | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL STAFF<br>DIRECTOR <input type="checkbox"/> PHYSICIAN <input type="checkbox"/> |   | 22c. DATE SIGNED<br><b>1/29/85</b> |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>Wm C March F. H Inc.</b>   |  | 22e. ADDRESS<br><b>1540 W. Balt St Baltimore, MD 21223</b>             |  |   |   |                                    |

|  |                            |   |   |
|--|----------------------------|---|---|
| 23a. BURIAL, CREMATION, REMOVAL<br><b>BURIAL</b>                                       | 23b. DATE<br><b>2/4/85</b> | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Garrison Forest VA Owings Mills, Md.</b> | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE      |
| 24. FUNERAL DIRECTOR<br>NAME ADDRESS<br><b>Wm C March F/H Inc. 1101 E North Avenue</b> |                            | 25a. DATE REC'D. BY REGISTRAR<br><b>JAN 31 1985</b>                               | 25b. REGISTRAR'S SIGNATURE<br><b>Wm C March</b> |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1-28-75-1

1-28-75-1

1-28-75-1

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with you after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be called.

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 5 0 1 6 2 5

1- FOR  
STATE  
REGISTRAR

REG. NO.

|   |  |  |  |   |  |   |   |   |  |  |  |
|---|--|--|--|---|--|---|---|---|--|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br><i>Leroy Thompson</i>  |  |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><i>1 3 85</i>                   |   |  | 2b. HOUR<br><i>10 36 PM</i>   |   |   |  |  |  |
| 3. SEX<br><i>Male</i>   |  | 4. RACE<br><i>Black</i>  |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><i>1 23 01</i>  |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><i>83</i> YRS.   |   | 7. UNDER 1 YEAR<br>MONTHS DAYS<br><i>8 5</i>                        |  | 8. UNDER 24 HRS.<br>HOURS MIN.<br><i>10 36</i> |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><i>Baltimore</i>   |  | 7b. CITIZEN OF WHAT COUNTRY?<br><i>USA</i>   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><i>Baltimore City</i> MD.                               |   |   |  |  |  |
| 10. CITY OR TOWN OF DEATH<br><i>Baltimore</i>   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><i>Luthern Hospital</i> |  |   |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><i>Long Shoreman</i>        |   |   | 12b. KIND OF BUSINESS OR INDUSTRY  |  |  |
| 13a. STATE<br><i>MD</i>   |  | 13b. COUNTY<br><i>Balt</i>   |  | 13c. CITY OR TOWN<br><i>Balt</i>  |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |   | 13e. STREET ADDRESS / ZIP CODE<br><i>1666 Poplar Grove St 21216</i> |  |  |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><i>James Thompson</i>   |  |  |  |   |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><i>Vilena Thompson</i>                         |   |   |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><i>No</i>   |  | 16b. SOCIAL SECURITY NO.<br><i>214-05-3837</i>   |  | 17. INFORMANT<br>ADDRESS<br><i>Vivien Gardner- 2101 KOKO Lane</i>   |  |   |   |   |  |  |  |
| 18. CAUSE OF DEATH: Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <i>cardiopulmonary arrest</i><br>DUE TO, OR AS A CONSEQUENCE OF:<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost:<br>(b) <i>sepsis</i><br>DUE TO, OR AS A CONSEQUENCE OF:<br>(c) _____ |  |  |  |   |  |   |   |   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH   |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: (c)  |  |  |  |   |  |   |   |   |  |  |  |
| 19a. DATE OF OPERATION  |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                       |   |  |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |   | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><i>P.M. 19</i>      |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) |   |   |   |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>   |  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                              |   |   |   |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <i>12/22</i> , 19 <i>84</i> , to <i>1/3</i> , 19 <i>85</i> , that (I) (we) lost<br>saw the deceased alive on <i>1/3</i> , 19 <i>85</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated<br>above, (I) (we) (did) (did not) view the body after death. |  |  |  |   |  |   |   |   |  |  |  |
| 22b. SIGNATURE<br><i>Mullen MD</i>  |  |  |  | DEGREE  |  |   |   | 22c. DATE SIGNED<br><i>1/3/85</i>                                   |  |  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><i>M. MULLEN MD</i>  |  |  |  | 22e. ADDRESS<br><i>Luthern Hosp</i>   |  |   |   |   |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br><i>Burial</i>  |  |  | 23b. DATE<br><i>1/5/85</i>   |   | 23c. NAME OF CEMETERY OR CREMATORY<br><i>ARBUTUS</i>                           |   |   | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><i>BALT. MARYLAND</i> |  |  |  |
| 24. FUNERAL DIRECTOR<br>NAME<br><i>2nd City &amp; Sons</i>  |  |  |  | ADDRESS<br><i>1701-BLAIRVIEW ST</i>   |  | 25a. DATE REC'D. BY REGISTRAR<br><i>JAN 7 1985</i>  |   | 25b. SIGNATURE<br><i>Maywood</i>                                    |  |  |  |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 1 and 2 should be detached for use as the burial-transit permit. Then please remove carbon copies. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 is marked, the medical examiner must be notified and a medical investigation must be conducted.

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

1- FOR  
STATE  
REGISTRAR

REG. NO.

|  |  |  |  |  |  |  |  |  |  |  |  |   |  |  |
|--|--|--|--|--|--|--|--|--|--|--|--|---|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)  |  |  | FIRST MIDDLE LAST  |  |  | 2a. DATE OF DEATH  |  |  | MONTH DAY YEAR   |  |  | 2b. HOUR  |  |  |
| LILLIAN  |  |  | THOMPSON   |  |  | 1/22/1985  |  |  | 0530AM   |  |  |   |  |  |
| 3. SEX   |  |  | 4. RACE  |  |  | 5. DATE OF BIRTH   |  |  | 6. AGE (IN YEARS LAST BIRTHDAY)                                |  |  | 7. UNDER 1 YEAR   |  |  |
| FEMALE   |  |  | CAUCASIAN  |  |  | 41 11 1895   |  |  | 89 YRS.  |  |  |   |  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)  |  |  | 7b. CITIZEN OF WHAT COUNTRY?   |  |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  |  | 9. BALTIMORE CITY OR COUNTY OF DEATH                           |  |  |   |  |  |
| Md.  |  |  | USA  |  |  |  |  |  | BALTIMORE CITY   |  |  | MD.   |  |  |
| 10. CITY OR TOWN OF DEATH  |  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) |  |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)  |  |  | 12b. KIND OF BUSINESS OR INDUSTRY                              |  |  |   |  |  |
| BALTIMORE  |  |  | SOUTH BALTIMORE GENERAL  |  |  | housewife  |  |  |  |  |  |   |  |  |
| 13a. USUAL RESIDENCE (IF NOT IN SUCH FACILITY, GIVE RESIDENCE BEFORE ADMISSION)  |  |  | 13b. CITY OR TOWN  |  |  | 13c. INSIDE CITY LIMITS?   |  |  | 13d. STREET ADDRESS / ZIP CODE                                 |  |  |   |  |  |
| MD   |  |  | PASADENA   |  |  | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>  |  |  | 7823 Harle Rd.   |  |  | 21122   |  |  |
| 14. FATHER'S NAME  |  |  | 15. MOTHER'S MAIDEN NAME   |  |  |  |  |  |  |  |  |   |  |  |
| Leo  |  |  | Homborg  |  |  | Della  |  |  | Airey  |  |  |   |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)  |  |  | 16b. SOCIAL SECURITY NO.   |  |  | 17. INFORMANT  |  |  | ADDRESS  |  |  |   |  |  |
| no   |  |  | 213 72 9469  |  |  | Ileine Thompson  |  |  | Balto. Md. 21225   |  |  |   |  |  |
|  |  |  |  |  |  |  |  |  | 201 E. Jeffrey St.   |  |  |   |  |  |
| 18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>CARDIAC ARREST</u>   |  |  |  |  |  |  |  |  |  |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><u>24 hrs</u> |  |  |
| DUE TO, OR AS A CONSEQUENCE OF<br>(b) <u>SEPSIS</u>  |  |  |  |  |  |  |  |  |  |  |  |   |  |  |
| DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____  |  |  |  |  |  |  |  |  |  |  |  |   |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: _____   |  |  |  |  |  |  |  |  |  |  |  |   |  |  |
| 19a. DATE OF OPERATION   |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  |  | 20a. AUTOPSY?  |  |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? |  |  |   |  |  |
|  |  |  |  |  |  | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  |  | YES <input type="checkbox"/> NO <input type="checkbox"/>       |  |  |   |  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19   |  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)   |  |  |  |  |  |   |  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> AT WORK<br>NOT WHILE <input type="checkbox"/> AT WORK   |  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                                 |  |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE  |  |  |  |  |  |   |  |  |
|  |  |  |  |  |  |  |  |  |  |  |  |   |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>January 15</u> , 19 <u>85</u> , to <u>January 22</u> , 19 <u>85</u> , that (I) (we) lost saw the deceased alive on <u>January 22</u> , 19 <u>85</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |  |  |  |  |  |  |  |  |  |  |  |   |  |  |
| 22b. SIGNATURE   |  |  | DEGREE   |  |  | 22c. DATE SIGNED   |  |  |  |  |  |   |  |  |
| <u>David L. Griswell</u>   |  |  |  |  |  | 1/22/85  |  |  |  |  |  |   |  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)  |  |  | 22e. ADDRESS   |  |  |  |  |  |  |  |  |   |  |  |
| DAVID L. GRISWELL  |  |  | SOUTH BALTIMORE GENERAL HOSPITAL   |  |  |  |  |  |  |  |  |   |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)  |  |  | 23b. DATE  |  |  | 23c. NAME OF CEMETERY OR CREMATORY   |  |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE                     |  |  |   |  |  |
| burial   |  |  | 1/25/85  |  |  | Holy Cross Cem.  |  |  | Brooklyn A.A. Md.  |  |  |   |  |  |
| 24. FUNERAL DIRECTOR   |  |  | 25a. DATE REC'D. BY REGISTRAR  |  |  | 25b. REGISTRAR'S SIGNATURE   |  |  |  |  |  |   |  |  |
| George J. Gonce  |  |  | 4001 Ritchie Hwy. Baltimore Md. 21225  |  |  | JAN 24 1985  |  |  | <u>John Davidson-Randall</u>                                   |  |  |   |  |  |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

FOR  
1 - STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 5 0 1 6 2 7

REG. NO.

|  |  |   |   |  |  |
|--|--|---|---|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>FIRST MIDDLE LAST<br><b>Theodore R. Thompson</b>  |  |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>January 23, 1985</b>            |  | 2b. HOUR<br>M<br><b>AM</b>   |
| 3. SEX<br><b>Male</b>  | 4. RACE<br><b>Black</b>  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>2 12 07</b>  |   | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>77</b> YRS.                                    | IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS.<br>HOURS MIN.   |
| 7. BIRTHPLACE<br>(STATE OR FOREIGN<br>COUNTRY)<br><b>S.C.</b>  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>   | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore City</b> MD.                    |  |
| 10. CITY OR TOWN OF DEATH<br><b>Baltimore</b>  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Provident Hospital</b> |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)          |  | 12b. KIND OF BUSINESS OR INDUSTRY  |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE<br><b>MD</b>   |  |   | 13b. COUNTY   | 13c. CITY OR TOWN<br><b>Baltimore</b>  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                            |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Henry Thompson</b>  |  |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Celia Roseborough</b> |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>No</b>  |  | 16b. SOCIAL SECURITY NO.<br><b>213-09-1464</b>  |   | 17. INFORMANT<br>ADDRESS<br><b>Celestine R. Thompson 3609 Springdale</b>             |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>myocardial Infarction</b>  |  |   |   |  | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH<br><b>30 min.</b>  |
| DUE TO, OR AS A CONSEQUENCE OF<br>(b) <b>Angina</b>  |  |   |   |  |  |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last  |  |   |   |  |  |
| DUE TO, OR AS A CONSEQUENCE OF<br>(c) <b>Diabetes</b>  |  |   |   |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)<br><b>Phlebitis</b>   |  |   |   |  |  |
| 19a. DATE OF OPERATION<br><b>5/10/76</b>   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>11/12/85</b>  |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)       |  |
| 21d. INJURY OCCURRED<br>WHERE <input type="checkbox"/> NOT WHERE <input type="checkbox"/><br>AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                    |  |
| 22a. I certify that (I) (the hospital) attended the deceased from <b>5/10/76</b> to <b>1/24/85</b> , that (we) lost<br>saw the deceased alive on <b>11/12/85</b> , and that in my (our) opinion death occurred on the date and hour and from the causes stated<br>above. (I) (we) (did not) view the body after death. |  |   |   |  |  |
| 22b. SIGNATURE<br><b>Richard H. Schlottman</b>   |  | DEGREE<br><b>MD</b>   |   | 22c. DATE SIGNED<br><b>1/25/85</b>   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>RICHARD H. SCHLOTTMAN, M.D.</b>  |  | 22e. ADDRESS<br><b>6000 PARK HEIGHTS AVE.</b>   |   |  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>Burial</b>  |  | 23b. DATE<br><b>1/28/85</b>   |   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Woodlawn Cem.</b>                           |  |
| 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Baltimore Co. MD</b>  |  | 24. FUNERAL DIRECTOR<br>NAME ADDRESS<br><b>Wm. C. March F/H 1101 E. North Ave.</b>  |   |  |  |
| 25a. DATE REC'D. BY REGISTRAR<br><b>JAN 24 1985</b>  |  | 25b. REGISTRAR'S SIGNATURE<br><b>[Signature]</b>  |   |  |  |

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PLANT  
INDUSTRY

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

FOR  
STATE  
REGISTRAR

REG. NO.

|   |  |   |   |   |  |
|---|--|---|---|---|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>Wm L. Thompson</b>                         |  |   | 2a. DATE OF DEATH MONTH DAY YEAR<br><b>11/19/85</b>   |   | 2b. HOUR<br><b>2:01</b> M                                      |
| 3. SEX<br><b>Male</b>   | 4. RACE<br><b>CAUCASIAN</b>  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>3 - 10 - 1913</b>  |   | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>71</b> YRS.                         | # UNDER 1 YEAR<br>MONTHS DAYS<br># UNDER 24 HRS.<br>HOURS MIN. |
| 7a. BIRTHPLACE<br>(STATE OR FOREIGN COUNTRY)<br><b>MD</b>                         | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U. S. A.</b>  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>BALTO. CITY</b> MD.            |  |
| 10. CITY OR TOWN OF DEATH<br><b>BALTO.</b>  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Francis Scott Key N.C.</b> |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>shipfitter</b>           |   | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>Beth Steel</b>         |
| 13a. USUAL RESIDENCE<br>13a. STATE<br><b>MD</b>                                   | 13b. COUNTY<br><b>BALTO</b>  | 13c. CITY OR TOWN<br><b>BALTO</b>   | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | 13e. STREET ADDRESS / ZIP CODE<br><b>3702 Chestle Pt BALTO. MD. 21224</b> |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>JAMES Thompson</b>                   |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Lucy Lasserty</b>   |   |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>NO</b> |  | 16b. SOCIAL SECURITY NO.<br><b>216-01-8857</b>  |   | 17. INFORMANT<br>ADDRESS<br><b>Mrs. Dorothy Thompson</b>                  |  |

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)  
PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) **Dementia**

DUE TO, OR AS A CONSEQUENCE OF

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.

(b) **Chronic Renal Failure**

DUE TO, OR AS A CONSEQUENCE OF

(c) **CHRONIC**

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)

|  |  |  |  |   |  |
|--|--|--|--|---|--|
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                       |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>      | 21i. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) |   |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                              |   |  |
| 22a. I certify that (I) (the hospital) attended the deceased from <b>11/2</b> , 19 <b>85</b> , to <b>11/19</b> , 19 <b>85</b> , that (I) (we) last saw the deceased alive on <b>11/19</b> , 19 <b>85</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (If we) (did) (did not) view the body after death. |  |  |  |   |  |
| 22b. SIGNATURE<br><b>Debra Swerthamer MD</b>   |  | DEGREE<br><b>MD</b>  |  | 22c. DATE SIGNED<br><b>11/20/85</b>                                       |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>DEBRA SWERTHAMER</b>   |  | 22e. ADDRESS<br><b>5702 EASTERN AVE.</b>                               |  |   |  |

|   |                             |   |  |
|---|-----------------------------|---|--|
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>BURIAL</b> | 23b. DATE<br><b>1/22/85</b> | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Sacred Heart Jesus</b> | 23d. LOCATION<br>CITY OR TOWN COUNTY<br><b>BALTO. MD</b> |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>ZANNINO FUNERAL HOME</b>   |                             | ADDRESS<br><b>263 South</b>                                     | 25a. DATE REC'D. BY REGISTRAR<br><b>JAN 21 1985</b>      |
| 25b. REGISTRAR'S SIGNATURE<br><b>Anna Davidson-Randall</b>    |                             |   |  |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Period may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, please 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.



Thompson

1888

DAVID

CHILD

2-40%



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

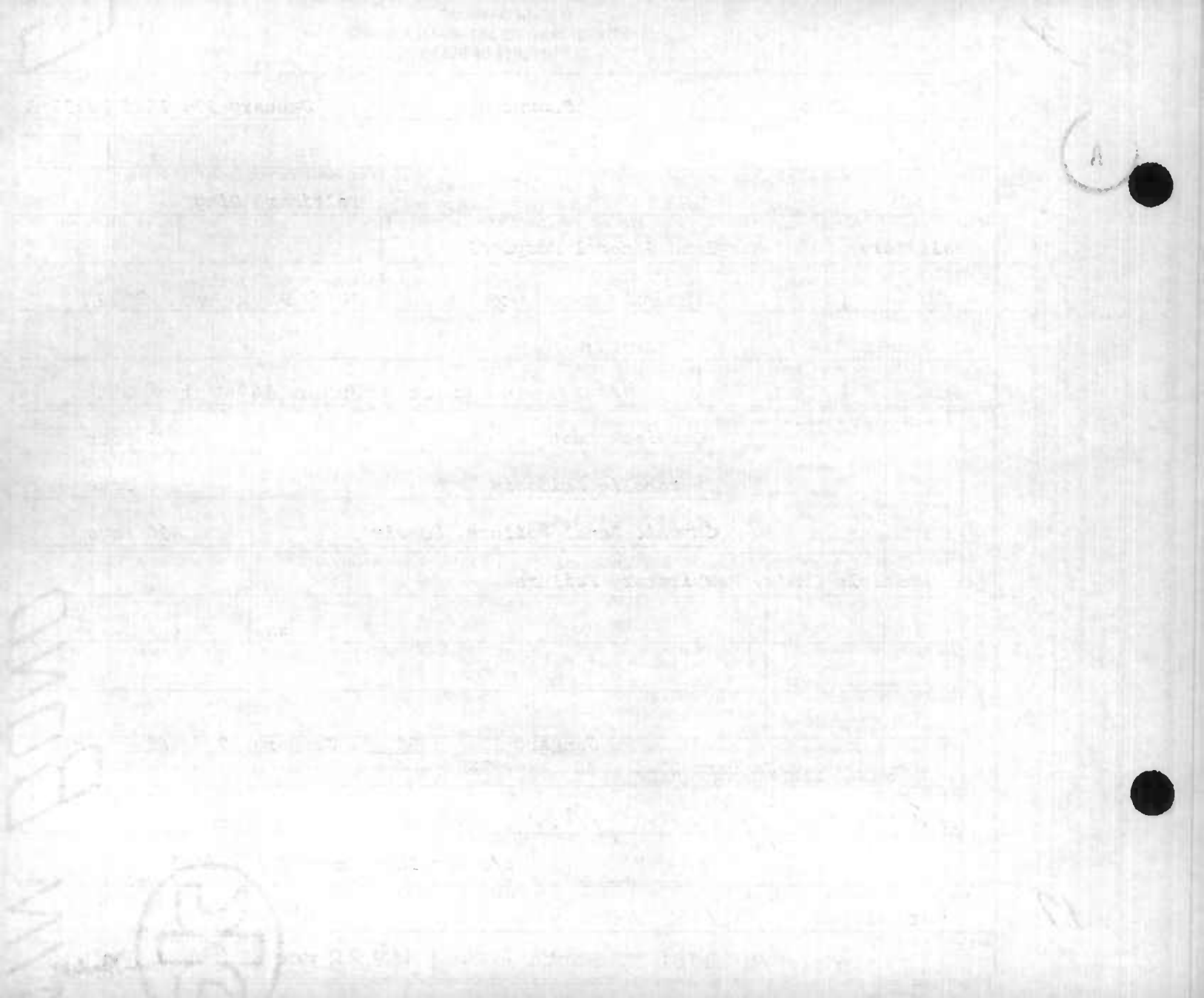
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use on the burial-transit permit. Then please remove carbon copies. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified through the coroner.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH   |  |   |  |   |  |  |  |  |  |
|--|--|---|--|---|--|--|--|--|--|
| 1. FOR<br>STATE<br>REGISTRAR   |  | REG. NO. 8 5 0 1 6 2 9  |  |   |  |  |  |  |  |
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>FIRST MIDDLE LAST<br><i>Emma Thornton</i>   |  |   |  |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><i>January 27, 1985</i> |  |  | 2b. HOUR<br><i>6:17 A.</i>   |  |
| 3. SEX<br><i>Female</i>  |  | 4. RACE<br><i>Black</i>   |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><i>6 4 06</i>   |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><i>79</i> YRS.  |  | IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS.<br>HOURS MIN.   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><i>MD</i>   |  | 7b. CITIZEN OF WHAT COUNTRY?<br><i>USA</i>  |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><i>Baltimore City</i> MD.  |  |  |  |
| 10. CITY OR TOWN OF DEATH<br><i>Baltimore</i>  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><i>Maryland General Hospital</i> |  |   |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)   |  | 12b. KIND OF BUSINESS OR INDUSTRY  |  |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE<br><i>MD</i>  |  | 13b. COUNTY   |  | 13c. CITY OR TOWN<br><i>Baltimore</i>   |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>  |  | 13e. STREET ADDRESS / ZIP CODE<br><i>2008 Park Ave. 21217</i>  |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><i>James Curtis</i>  |  |   |  |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><i>-</i>      |  |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)<br><i>No</i>  |  | 16b. SOCIAL SECURITY NO.<br><i>N/A</i>  |  | 17. INFORMANT<br>ADDRESS<br><i>Margaret Johnson 447 Watty Ct.</i>   |  |  |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <i>Cardiac Arrest</i>   |  |   |  |   |  |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><i>1 Hour</i>  |  |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.<br>DUE TO, OR AS A CONSEQUENCE OF (b) <i>Metabolic Acidosis</i>   |  |   |  |   |  |  |  | <i>4 Days</i>  |  |
| DUE TO, OR AS A CONSEQUENCE OF (c) <i>Chronic Renal Failure, Sepsis</i>  |  |   |  |   |  |  |  | <i>10 Days</i>   |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: (a)<br><i>Multiple CVA's, Respiratory Failure</i>   |  |   |  |   |  |  |  |  |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  |   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)  |  |  |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |  |  |  |  |
| 22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <i>January 1</i> , 19 <i>85</i> , to <i>January 27</i> , 19 <i>85</i> , that <input checked="" type="checkbox"/> (we) lost<br>saw the deceased alive on <i>January 27</i> , 19 <i>85</i> , and that in <input checked="" type="checkbox"/> (our) opinion death occurred on the date and hour and from the causes stated<br>above. <input checked="" type="checkbox"/> (we) did <input checked="" type="checkbox"/> not view the body after death. |  |   |  |   |  |  |  |  |  |
| 22b. SIGNATURE<br><i>Larry W. Epperson, M.D.</i>   |  |   |  |   |  | DEGREE<br>ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> |  | 22c. DATE SIGNED   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)  |  |   |  |   |  | 22e. ADDRESS<br><i>c/o Maryland General Hospital</i>   |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><i>Burial</i>  |  | 23b. DATE<br><i>1/31/85</i>   |  | 23c. NAME OF CEMETERY OR CREMATORY<br><i>Eastview Mem. Pk.</i>  |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><i>Baltimore MD</i>  |  |  |  |
| 24. FUNERAL DIRECTOR<br>NAME<br><i>Wm. C. March F/H</i>  |  |   |  |   |  | ADDRESS<br><i>1101 E. North Ave.</i>   |  | 25a. DATE REC'D. BY REGISTRAR<br><i>JAN 28 1985</i>  |  |
|  |  |   |  |   |  | 25b. REGISTRAR'S SIGNATURE<br><i>John Davidson-Rodden</i>  |  |  |  |

BP 12





TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM-3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

| FOR<br>1- STATE<br>REGISTRAR  |  | STATE OF MARYLAND<br>MEDICAL EXAMINER'S CERTIFICATE OF DEATH |  |  |  |  |  |   |  |                  |  | REG. NO. 01630   |  |  |  |
|---|--|--|--|--|--|--|--|---|--|------------------|--|--|--|--|--|
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST<br><b>FRANKLIN U. THORNTON</b>   |  |  |  |  |  |  |  |   |  |                  |  | 2a. DATE KNOWN OF DEATH ESTI- MATED <input checked="" type="checkbox"/> MONTH DAY YEAR<br><b>1-12-85</b> |  | 2b. HOUR<br><b>M</b>                         |  |
| 3. SEX<br><b>M</b>  |  | 4. RACE<br><b>B</b>  |  | 5. DATE OF BIRTH MONTH DAY YEAR<br><b>2 27 34</b>  |  | 6. AGE (IN YEARS LAST BIRTHDAY) MONTHS DAYS HOURS MIN.<br><b>50 YRS.</b> |  | IF UNDER 1 YR.  |  | IF UNDER 24 HRS. |  | 2c. DATE PRONOUNCED DEAD MONTH DAY YEAR<br><b>1-12-85</b>  |  | 2d. HOUR<br><b>5:55A</b>                     |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Baltimore MD</b>  |  |  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>   |  |  |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  |                  |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore City</b>  |  |  |  |
| 10. CITY OR TOWN OF DEATH<br><b>Baltimore</b>   |  |  |  | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>2041 W. North Avenue</b> |  |  |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>LABORER</b>   |  |                  |  | 12b. KIND OF BUSINESS OR INDUSTRY  |  |  |  |
| 13a. STATE<br><b>MD</b>   |  |  |  | 13b. COUNTY<br><b>Baltimore</b>  |  |  |  | 13c. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>  |  |                  |  | 13d. STREET ADDRESS<br><b>2041 W NORTH AVE</b>   |  |  |  |
| 14. FATHER'S NAME FIRST MIDDLE LAST<br><b>Gregory Thornton</b>  |  |  |  | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST<br><b>Elizbeth Whiting</b>  |  |  |  |   |  |                  |  |  |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)<br><b>NO</b>   |  |  |  | 16b. SOCIAL SECURITY NO.<br><b>216-32-1134</b>   |  |  |  | 17. INFORMANT ADDRESS<br><b>JENNIE THORNTON 5 N Mount St</b>  |  |                  |  |  |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Arteriosclerotic cardiovascular disease</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost. }<br>(b) DUE TO, OR AS A CONSEQUENCE OF<br>(c)<br>PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)<br><b>seizure disorder</b> |  |  |  |  |  |  |  |   |  |                  |  |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |  |
| 19a. DATE OF OPERATION  |  |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?  |  |  |  |   |  |                  |  | 20. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                      |  |  |  |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH   |  |  |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>   |  |  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)   |  |                  |  |  |  |  |  |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  |  |  |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)  |  |  |  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE  |  |                  |  |  |  |  |  |
| 22a. I certify that I took charge of the remains described above, held on death resulted from: <b>Natural causes</b> <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion   |  |  |  |  |  |  |  |   |  |                  |  |  |  |  |  |
| ACTUAL SIGNATURE<br>  |  |  |  | TITLE (SPECIFY)<br><b>M.D. Assistant</b>   |  |  |  | DATE SIGNED<br><b>1-12-85</b>   |  |                  |  |  |  |  |  |
| EXAMINER'S NAME (TYPE OR PRINT)<br><b>Gregory R. Kauffman, M.D.</b>   |  |  |  | ADDRESS<br><b>111 Penn Street</b>  |  |  |  |   |  |                  |  |  |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>Burial</b>  |  |  |  | 23b. DATE<br><b>1/5/85</b>   |  |  |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>MD Veterans</b>  |  |                  |  | 23d. LOCATION CITY OR TOWN COUNTY STATE<br><b>Crownsville, MD</b>  |  |  |  |
| 24. FUNERAL DIRECTOR NAME<br><b>Theresa R. Hanger</b>   |  |  |  | ADDRESS<br><b>635 N 9th Ave St</b>   |  |  |  | 25a. DATE REC'D. BY REGISTRAR<br><b>JAN 14 1985</b>   |  |                  |  | 25b. REGISTRAR'S SIGNATURE<br>   |  |  |  |

92844 NOTED 800

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W/AT



DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 5 0 1 6 3 1

FOR  
1 - STATE  
REGISTRAR

REG. NO.

|  |  |   |  |  |  |
|--|--|---|--|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>JAMES M. MIDDLE TILLER, SR.</b>   |  | 2a. DATE OF DEATH MONTH DAY YEAR<br><b>Jan 20 '85</b>   |  | 2b. HOUR<br><b>10<sup>12</sup> PM</b>  |  |
| 3 SEX<br><b>Male</b>   |  | 4 RACE<br><b>White</b>  |  | 5. DATE OF BIRTH MONTH DAY YEAR<br><b>Feb. 23, 1893</b>                              |  |
| 6 AGE (IN YEARS LAST BIRTHDAY)<br><b>91</b>  |  | 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>West Virginia</b>   |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>   |  |
| 8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9 BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore County</b> MD.  |  |  |  |
| 10 CITY OR TOWN OF DEATH<br><b>Baltimore</b>   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN STATE, GIVE STATE)<br><b>Mercy Hospital</b>   |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK OR MOST OF WORKING LIFE)<br><b>Serviceman</b> |  |
| 12b. KIND OF BUSINESS OR<br>INDUSTRY<br><b>US Army</b>   |  | 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE <b>Maryland</b> 13b. CITY OR TOWN <b>Baltimore</b> 13c. STREET ADDRESS<br><b>Essex</b> |  |  |  |
| 14 FATHER'S NAME FIRST MIDDLE LAST<br><b>Wiley Tiller</b>  |  | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST<br><b>Mary Shrewsbury</b>  |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>Yes</b>   |  | 16b. SOCIAL SECURITY NO.<br><b>1916-46</b>  |  | 17 INFORMANT ADDRESS<br><b>Nancy Smith, Daughter Same</b>                            |  |

|  |  |  |  |   |  |
|--|--|--|--|---|--|
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Cardiopulmonary Arrest</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <b>Acute Myocardial Infarction</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <b>Cardiac Arrhythmia</b>                    |  |  |  | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH                           |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a):<br><b>Chronic Renal Failure</b>   |  |  |  |   |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 20b. IF YES, WERE FINDINGS USED<br>IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>  |  | 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER) |  |   |  |
| 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)   |  |   |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                         |  |
| 22a. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) last<br>saw the deceased alive on _____, 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated<br>above, (I) (we) (did) (did not) view the body after death. |  |  |  |   |  |
| 22b. SIGNATURE<br><b>Michael Schwartz M.D.</b>   |  |  |  | 22c. DATE SIGNED<br><b>1/21/85</b>  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>Michael Schwartz, M.D.</b>   |  |  |  | 22e. ADDRESS<br><b>606 Hammonds Lane 21225</b>                            |  |

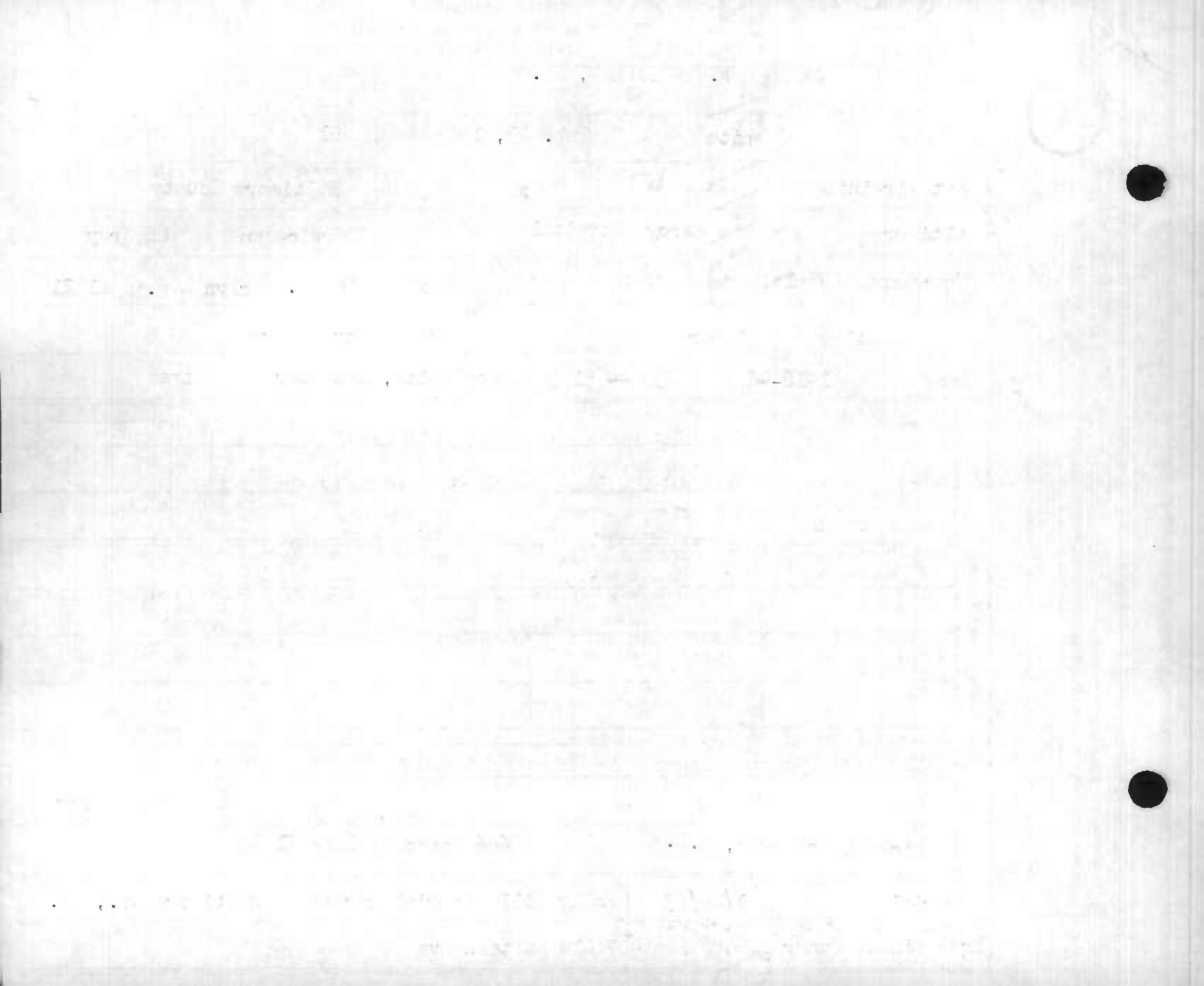
|   |  |                             |  |  |  |   |  |
|---|--|-----------------------------|--|--|--|---|--|
| 23a. BURIAL, CREMATION, REMOVAL<br><b>Burial</b>                                |  | 23b. DATE<br><b>1/24/85</b> |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Holly Hill Memorial Gardens</b> |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Baltimore Co., Md.</b> |  |
| 24. FUNERAL DIRECTOR<br><b>Brazdzinski Funeral Home PA 1407 Old Eastern Ave</b> |  |                             |  | 25a. DATE REC'D. BY REGISTRAR<br><b>JAN 23 1985</b>                      |  | 25b. REGISTRAR'S SIGNATURE<br><b>[Signature]</b>                        |  |

BP

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours of death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, a medical examiner must be notified.



STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1- FOR  
STATE  
REGISTRAR

|  |  |   |  |   |  |  |  |   |  |   |  |
|--|--|---|--|---|--|--|--|---|--|---|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>BERTHA W. TIPPEN</b>                            |  |   | 2a. DATE OF DEATH<br>MONTH <b>1</b> DAY <b>10</b> YEAR <b>85</b> |   |  | 2b. HOUR<br><b>8:30 P.M.</b>   |  |   |  |   |  |
| 3. SEX<br><b>FEMALE</b>  |  | 4. RACE<br><b>CAU.</b>  |  | 5. DATE OF BIRTH<br>MONTH <b>9</b> DAY <b>27</b> YEAR <b>13</b>   |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>71</b> YRS                                     |  | 7. IF UNDER 1 YEAR<br>MONTHS <b></b> DAYS <b></b>   |  | 8. IF UNDER 24 HRS.<br>HOURS <b></b> MIN. <b></b>                 |  |
| 7a. BIRTHPLACE<br>(STATE OR FOREIGN COUNTRY)<br><b>PENNA.</b>                          |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore City</b> MD.                    |  |   |  |   |  |
| 10. CITY OR TOWN OF DEATH<br><b>Baltimore</b>  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(DO NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>DEATON MEDICAL CENTER</b> |  |   |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Homemaker</b> |  |   | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>OWN HOME</b> |   |  |
| 13a. STATE<br><b>MARYLAND</b>  |  |   |  | 13b. COUNTY<br><b>ANNE ARUNDEL</b>  |  | 13c. CITY OR TOWN<br><b>BALTIMORE</b>  |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 13e. STREET ADDRESS / ZIP CODE<br><b>420 HOLY CROSS RD. 21225</b> |  |
| 14. FATHER'S NAME<br>FIRST <b>BENJAMIN</b> MIDDLE <b>WILLIAMS</b> LAST <b>WILLIAMS</b> |  |   |  | 15. MOTHER'S MAIDEN NAME<br>FIRST <b>ANNIE</b> MIDDLE <b>M.</b> LAST <b>JONES</b>   |  |  |  |   |  |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>NO</b>      |  | 16b. SOCIAL SECURITY NO.<br><b>219-14-6748</b>  |  | 17. INFORMANT<br>ADDRESS<br><b>Virginia Neilson, Baltimore MD.</b>  |  |  |  |   |  |   |  |

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).  
PART 1. DEATH WAS CAUSED BY.

IMMEDIATE CAUSE (a)

**CHF**APPROXIMATE INTERVAL  
BETWEEN ONSET AND DEATH**6 months**

Conditions, if any, which  
gave rise to immediate  
cause (a), stating the  
underlying cause last.

DUE TO, OR AS A CONSEQUENCE OF

(b)

**AS HP**

DUE TO, OR AS A CONSEQUENCE OF

(c)

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

**Renal Failure**

|  |  |  |  |  |  |   |  |
|--|--|--|--|--|--|---|--|
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                       |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  | 20b. IF YES, WERE FINDINGS USED<br>IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19             |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)   |  |   |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE  |  |   |  |
| 22a. I certify that (a) (this hospital) attended the deceased from <b>1/10/85</b> to <b>1/10/85</b> , that (we) last<br>saw the deceased alive on <b>1/10/85</b> , and that in (my/our) opinion death occurred on the date and hour and from the causes stated<br>above; (b) (we) (did) (did not) view the body after death. |  |  |  |  |  |   |  |
| 22b. SIGNATURE<br><b>J.P. Gladeu, MD</b>   |  | DEGREE   |  | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input checked="" type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |  | 22c. DATE SIGNED<br><b>1/10/85</b>  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>J.P. GLADEU, M.D.</b>  |  | 22e. ADDRESS<br><b>BALTIMORE MARYLAND</b>                              |  |  |  |   |  |

|   |  |                                   |  |  |  |  |  |
|---|--|-----------------------------------|--|--|--|--|--|
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>BURIAL</b>     |  | 23b. DATE<br><b>JAN. 13, 1985</b> |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>ST. MICHAELS CEM.</b> |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>FROSTBURG, ALLEGANY MD.</b> |  |
| 24. FUNERAL DIRECTOR<br><b>DURST FUNERAL HOME, FROSTBURG, MD.</b> |  |                                   |  | 25. DATE OF DEATH<br><b>JAN 2 3 1985</b>                       |  |  |  |

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TO HOSPITAL OR ATTENDING PHYSICIAN. The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

FOR  
1 - STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 5

0 1 6 3 3

REG. NO.

|  |  |  |   |  |  |  |  |  |   |  |  |   |  |  |
|--|--|--|---|--|--|--|--|--|---|--|--|---|--|--|
| 1 DECEASED NAME<br>(TYPE OR PRINT) <b>WILLIAM</b>  |  |  | FIRST <b>LOHLIVER</b>   |  |  | LAST   |  |  | 2a. DATE OF DEATH MONTH <b>01</b> DAY <b>18</b> YEAR <b>85</b>  |  |  | 2b. HOUR <b>6:25</b> M                                      |  |  |
| 3 SEX <b>Male</b>  |  |  | 4 RACE <b>White</b>   |  |  | 5. DATE OF BIRTH MONTH <b>05</b> DAY <b>29</b> YEAR <b>06</b>  |  |  | 6 AGE (IN YEARS LAST BIRTHDAY) <b>78</b>  |  |  | 7 UNDER 1 YEAR MONTHS <b>0</b> DAYS <b>0</b>                |  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)  |  |  | 7b. CITIZEN OF WHAT COUNTRY?  |  |  | 8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  |  | 9 BALTIMORE CITY OR COUNTY OF DEATH <b>Baltimore</b>  |  |  | MD.   |  |  |
| 10 CITY OR TOWN OF DEATH <b>Baltimore</b>  |  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Greiner Deaf &amp; Blind Asylum</b> |  |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)  |  |  | 12b. KIND OF BUSINESS OR INDUSTRY   |  |  |   |  |  |
| 13a. STATE <b>MD</b>   |  |  | 13b. COUNTY <b>Baltimore</b>  |  |  | 13c. CITY OR TOWN <b>Baltimore</b>   |  |  | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                            |  |  | 13e. STREET ADDRESS <b>607 West 21st Ave</b>                |  |  |
| 14 FATHER'S NAME FIRST <b>WILLIAM</b> MIDDLE <b>LOHLIVER</b> LAST <b>LOHLIVER</b>  |  |  | 15. MOTHER'S MAIDEN NAME FIRST <b>WILLIAM</b> MIDDLE <b>LOHLIVER</b> LAST <b>LOHLIVER</b>   |  |  | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)  |  |  | 16b. SOCIAL SECURITY NO. <b>729-12-1916</b>   |  |  | 17 INFORMANT ADDRESS <b>Greiner Deaf &amp; Blind Asylum</b> |  |  |
| 18 CAUSE OF DEATH (Enter only one cause per line (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>PROSTATE CANCER</b>   |  |  |   |  |  |  |  |  |   |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>YRS</b>     |  |  |
| DUE TO, OR AS A CONSEQUENCE OF (b) _____   |  |  |   |  |  |  |  |  |   |  |  |   |  |  |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last  |  |  |   |  |  |  |  |  |   |  |  |   |  |  |
| DUE TO, OR AS A CONSEQUENCE OF (c) <b>GI BLEEDING</b>  |  |  |   |  |  |  |  |  |   |  |  |   |  |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <b>COPD</b>   |  |  |   |  |  |  |  |  |   |  |  |   |  |  |
| 19a. DATE OF OPERATION   |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  |  | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>   |  |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> |  |  |   |  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |  |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>19</b>  |  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)   |  |  |   |  |  |   |  |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  |  |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |  |  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE   |  |  |   |  |  |   |  |  |
| 22a. I certify that (I) (the undersigned) attended the deceased from <b>01-02-85</b> to <b>01-18-85</b> , that (I) (the undersigned) saw the deceased alive on <b>01-17-85</b> , and that in (my) (the undersigned's) opinion death occurred on the date and hour and from the causes stated above. (If (you) (did) (not) view the body after death. |  |  |   |  |  |  |  |  |   |  |  |   |  |  |
| 22b. SIGNATURE <b>Richard Tyson</b>  |  |  | DEGREE <b>MD</b>  |  |  | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>   |  |  | 22c. DATE SIGNED <b>01-18-85</b>  |  |  |   |  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>RICHARD TYSON</b>   |  |  | 22e. ADDRESS <b>936 W. NORTH AVE, BALTIMORE MD 21217</b>  |  |  |  |  |  |   |  |  |   |  |  |
| 23a. BURIAL, CREMATION, REMOVAL <b>Burial</b>  |  |  | 23b. DATE <b>1/25/85</b>  |  |  | 23c. NAME OF CEMETERY OR CREMATORY <b>Wm. Anderson &amp; Co.</b>   |  |  | 23d. LOCATION CITY OR TOWN COUNTY STATE <b>Baltimore City Md</b>  |  |  |   |  |  |
| 24 FUNERAL DIRECTOR NAME <b>Canell</b> ADDRESS <b>1712 W. North</b>  |  |  | 25a. DATE REC'D. BY REGISTRAR <b>JAN 22 1985</b>  |  |  | 25b. REGISTRAR'S SIGNATURE <b>John Davidson</b>  |  |  |   |  |  |   |  |  |



#18, 22a, Film G600 2/13/85 kam  
 STATE OF MARYLAND  
 DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

|  |                              |                  |   |                   |   |   |   |  |
|--|------------------------------|------------------|---|-------------------|---|---|---|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)  |                              |                  | 2a. DATE KNOWN OF DEATH   |                   |   | 2b. HOUR  |   |  |
| FIRST MIDDLE LAST<br>Anna Jeanette Tolson  |                              |                  | ESTIMATED MONTH DAY YEAR<br>1/ 2/ 19 85   |                   |   | 24 HOUR<br>11:25 AM   |   |  |
| 3. SEX   | 4. RACE                      | 5. DATE OF BIRTH | 6. AGE (IN YEARS)   | IF UNDER 1 YR.    | IF UNDER 24 HRS.  | 2c. DATE PRONOUNCED DEAD                                      |   |  |
| Female   | Caucasian                    | 6-18-1921        | 63 YRS.   |                   |   | 1/ 2/ 1985  |   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)  | 7b. CITIZEN OF WHAT COUNTRY? |                  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |                   |   | 9. BALTIMORE CITY OR COUNTY OF DEATH                          |   |  |
| Maryland   | USA                          |                  |   |                   |   | Baltimore City, MD.   |   |  |
| 10. CITY OR TOWN OF DEATH  |                              |                  | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)  |                   |   | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) |   | 12b. KIND OF BUSINESS OR INDUSTRY            |
| Baltimore  |                              |                  | 3526 Horton Ave.  |                   |   | Homemaker   |   | Domestic                                     |
| 13a. STATE   |                              |                  | 13b. COUNTY   | 13c. CITY OR TOWN | 13d. INSIDE CITY LIMITS?  | 13e. STREET ADDRESS   |   |  |
| Maryland   |                              |                  |   | Baltimore         | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>           | 3526 Horton Avenue 21225                                      |   |  |
| 14. FATHER'S NAME  |                              |                  | 15. MOTHER'S MAIDEN NAME  |                   |   |   |   |  |
| FIRST MIDDLE LAST<br>Charles Byron Warfield  |                              |                  | FIRST MIDDLE LAST<br>Liza Cannoll   |                   |   |   |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO, OR UNKNOWN)  |                              |                  | 16b. SOCIAL SECURITY NO.  |                   | 17. INFORMANT ADDRESS   |   |   |  |
| No   |                              |                  | 216-80-0869   |                   | Arthur W. Tolson Same as #13  |   |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I DEATH WAS CAUSED BY:   |                              |                  |   |                   |   |   |   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| IMMEDIATE CAUSE (a) <u>Arteriosclerotic cardiovascular disease</u>   |                              |                  |   |                   |   |   |   |  |
| DUE TO, OR AS A CONSEQUENCE OF   |                              |                  |   |                   |   |   |   |  |
| Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last:  |                              |                  |   |                   |   |   |   |  |
| (b) _____  |                              |                  |   |                   |   |   |   |  |
| DUE TO, OR AS A CONSEQUENCE OF   |                              |                  |   |                   |   |   |   |  |
| (c) _____  |                              |                  |   |                   |   |   |   |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a).  |                              |                  |   |                   |   |   |   |  |
| 19a. DATE OF OPERATION   |                              |                  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?   |                   |   |   | 20. AUTOPSY?  |  |
|  |                              |                  |   |                   |   |   | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH  |                              |                  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |                   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) |   |   |  |
|  |                              |                  |   |                   |   |   |   |  |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>   |                              |                  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)   |                   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                             |   |   |  |
|  |                              |                  |   |                   |   |   |   |  |
| 22a. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> |                              |                  |   |                   |   |   |   |  |
| ACTUAL SIGNATURE <u>Thomas D. Smith</u>  |                              |                  |   |                   | TITLE (SPECIFY)<br>M.D. Dep. Chief  |   | DATE SIGNED 1/2/85  |  |
| EXAMINER'S NAME (TYPE OR PRINT) Thomas D. Smith, M.D.  |                              |                  |   |                   | ADDRESS 111 Penn St.  |   |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)  |                              |                  | 23b. DATE   |                   | 23c. NAME OF CEMETERY OR CREMATORY  |   | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE                          |  |
| Burial   |                              |                  | 1-5-85  |                   | Cedar Hill Cemetery   |   | Baltimore Anne Arundel Md   |  |
| 24. FUNERAL DIRECTOR NAME  |                              |                  | ADDRESS   |                   | 25a. DATE REC'D. BY REGISTRAR   |   | 25b. REGISTRAR'S SIGNATURE  |  |
| Mc Cully Funeral Home  |                              |                  | 237 E. Patapsco Ave Baltimore, Md 21225   |                   | JAN 4 1985  |   | John Davidson-Randall   |  |

RECEIVED  
MOTOR & CO



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon-copies. Pages 1 and 2 should be filed within 72 hours of death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of once.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH  |   |   |   |  | 8 5 0 1 6 3 5  |  |
|---|---|---|---|--|--|--|
| 1- FOR STATE REGISTRAR  |   |   | REG. NO.  |  |  |  |
| 1. DECEASED NAME (TYPE OR PRINT)<br><b>Romaine G. Tolson</b>  |   |   | 2a. DATE OF DEATH<br><b>January 23, 1985</b>  |  | 2b. HOUR<br><b>10:00 A.M.</b>                                      |  |
| 3. SEX<br><b>Female</b>   | 4. RACE<br><b>White</b>   | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>Sept. 7, 1913</b>  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>71</b> YRS.   |  | IF UNDER 1 YEAR<br>MONTHS DAYS HOURS MIN.                          |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Baltimore, Md.</b>  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U. S. A.</b>   | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore City, MD.</b>                              |  |  |  |
| 10. CITY OR TOWN OF DEATH<br><b>Baltimore</b>   | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOW IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>5433 Radecke Avenue</b> |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Secretary</b>            |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>Tailoring Co.</b>          |  |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE <b>Md</b> 13b. COUNTY <b>----</b> 13c. CITY OR TOWN <b>Baltimore</b>   |   |   | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 13. STREET ADDRESS / ZIP CODE<br><b>5433 Radecke Avenue 21206.</b> |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>William S. O'Neil</b>  |   |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Elsie -- Lucas</b>                          |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NOT UNKNOWN) <b>No</b>  |   | 16b. SOCIAL SECURITY NO.<br><b>214-03-7721</b>  |   | 17. INFORMANT <b>Baltimore, Md. 21206.</b><br><b>Charles F. Tolson-5433 Radecke Ave.</b> |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Probable Vent. Fibrillation</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <u>Myocardial Ischemia</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <u>ASIA</u>  |   |   |   |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH   |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <u>----</u>  |   |   |   |  |  |  |
| 19a. DATE OF OPERATION  |   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>                |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |   | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>   |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)           |  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>  |   | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>Jan</u> , 19 <u>85</u> , to <u>Present</u> , 19 <u>85</u> , that (I) (we) lost saw the deceased alive on <u>1/14/85</u> , 19 <u>85</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |   |   |   |  |  |  |
| 22b. SIGNATURE<br><u>Michael F. Chitt</u>   |   | DEGREE<br>ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>        |   | 22c. DATE SIGNED<br><u>1/23/85</u>   |  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)   |   | 22e. ADDRESS<br><u>100 E. Pleasant St. Balt 21202</u>   |   |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>Burial</b>  |   | 23b. DATE<br><b>1/26/85</b>   |   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Gardens of Faith Cem.</b>                       |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Baltimore, Maryland</b>   |
| 24. FUNERAL DIRECTOR <b>John A. Moran, Inc. Funeral Home</b><br>NAME ADDRESS<br><b>3000 E. Baltimore St., Balto., Md. 21224.</b>  |   |   |   | 25. DATE REC'D. BY REGISTRAR<br><b>JAN 24 1985</b>                                       |  |  |
| 26. REGISTRAR'S SIGNATURE<br><u>Julia Davidson-Randall</u>  |   |   |   |  |  |  |

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STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 5 0 1 6 3 6

REG. NO.

FOR  
1 - STATE  
REGISTRAR

|   |   |   |  |  |   |
|---|---|---|--|--|---|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>FIRST MIDDLE LAST<br><b>CICERO M TONEY</b>   |   |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>JANUARY 15, 1985</b>       |  | 2b. HOUR<br>A<br><b>1:10</b><br>M   |
| 3. SEX<br><b>Male</b>   | 4. RACE<br><b>black</b>   | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>2 4 17</b>   |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>67</b> YRS.                                    | 7. UNDER 1 YEAR<br>MONTHS DAYS<br><b>67</b>   |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Littleton, N.C.</b>   | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>   | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>BALTIMORE CITY</b> MD.                    |   |
| 10. CITY OR TOWN OF DEATH<br><b>BALTIMORE</b>   | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(GIVE FULL NAME AND STREET ADDRESS)<br><b>JOHNS HOPKINS HOSPITAL</b> |   |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Checker</b>   | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>Auto</b>  |
| 13. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE <b>Md.</b> 13b. COUNTY <b>Balto</b> 13c. CITY OR TOWN <b>Turners</b> 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> 13e. STREET ADDRESS / ZIP CODE <b>405 MAIN ST. 21222</b>                                    |   |   |  |  |   |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Fletcher Toney</b>   |   |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Marie Harris</b> |  |   |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) <b>yes</b>   |   | 16b. SOCIAL SECURITY NO.<br><b>218 10 0392</b>  |  | 17. INFORMANT ADDRESS<br><b>Emma Toney 405 MAIN STREET.</b>                          |   |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>hypotension</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <b>sepsis</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <b>acute myelogenous leukemia</b>   |   |   |  |  | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH<br><b>24 hrs</b><br><b>3 days</b><br><b>2 months</b>                          |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 11a   |   |   |  |  |   |
| 19a. DATE OF OPERATION  |   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 20b. IF YES, WERE FINDINGS USED<br>IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |   | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>19</b>  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)       |   |
| 21d. INJURY OCCURRED<br>WHERE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>   |   | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                    |   |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>Jan 7</b> , 19 <b>85</b> , to <b>Jan 15</b> , 19 <b>85</b> , that (I) (we) last saw the deceased alive on <b>Jan 15</b> , 19 <b>85</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |   |   |  |  |   |
| 22b. SIGNATURE<br><b>Gina Dallabetta</b>  |   | DEGREE<br><b>MD</b>   |  | 22c. DATE SIGNED<br><b>1/15/85</b>   |   |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>Gina Dallabetta</b>   |   | 22e. ADDRESS<br><b>600 N. WOLFE ST. BALTO, MD. 21205</b><br><b>JOHNS HOPKINS HOSPITAL</b>   |  |  |   |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>CREMATION</b>  |   | 23b. DATE<br><b>1/19/85</b>   |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Westview</b>                                |   |
| 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Balto Md.</b>  |   | 23e. DATE REC'D. BY REGISTRAR<br><b>JAN 16 1985</b>   |  |  |   |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>JAS. A. MORTON &amp; SONS</b>  |   | ADDRESS<br><b>1701 Laurens</b>  |  | 25. REGISTRAR'S SIGNATURE<br><b>Julia Davidson-Randall</b>                           |   |

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 when any injury, or other traumatic event, the medical examiner must be notified at once.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH  |  |  |   |  |   |   |  |   |  |  |
|---|--|--|---|--|---|---|--|---|--|--|
| 1. FOR STATE REGISTRAR  |  |  |   |  | REG. NO.  |   |  |   |  |  |
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>ETHEL G. TORAN</b>   |  |  |   |  | 2a. DATE OF DEATH MONTH DAY YEAR <b>Jan. 27, 1985</b> 2b. HOUR <b>12 noon</b> M   |   |  |   |  |  |
| 3. SEX <b>Female</b>  |  | 4. RACE <b>Negroid</b>   |   | 5. DATE OF BIRTH MONTH DAY YEAR <b>Mar. 4, 1925</b>  |   | 6. AGE (IN YEARS LAST BIRTHDAY) <b>59</b> YRS                                 |  | 7. IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.  |  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>North Carolina</b>   |  | 7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A</b>  |   | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. BALTIMORE CITY OR COUNTY OF DEATH <b>Balto. City</b> MD                    |  |   |  |  |
| 10. CITY OR TOWN OF DEATH <b>Balto.</b>   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>1312 Homestead St.</b> |   |  |   | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Disabled</b> |  | 12b. KIND OF BUSINESS OR INDUSTRY   |  |  |
| 13a. STATE <b>Md.</b>   |  |  | 13b. COUNTY   |  | 13c. CITY OR TOWN <b>Baltimore</b>  |   | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |   | 13e. STREET ADDRESS / ZIP CODE <b>1312 Homestead 21218</b> |  |
| 14. FATHER'S NAME FIRST MIDDLE LAST <b>CHARLIE SCOTT</b>  |  |  |   |  | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>DOVA Williams</b>   |   |  |   |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>NO</b>   |  |  | 16b. SOCIAL SECURITY NO. <b>214-38-2068</b>                         |  | 17. INFORMANT ADDRESS <b>JEANETTE THORNE 5226 Darien Rd.</b>  |   |  |   |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY<br>IMMEDIATE CAUSE (a) <b>Metastatic Mastoid Carcinoma</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____<br>DUE TO, OR AS A CONSEQUENCE OF (c) _____ |  |  |   |  |   |   |  |   |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a) _____  |  |  |   |  |   |   |  |   |  |  |
| 19a. DATE OF OPERATION  |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                    |  |   | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>        |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> |  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |  |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. <b>19</b>         |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18. PART 1 OR PART 2)  |   |  |   |  |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>  |  |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) |  | 21f. LOCATION CITY OR TOWN COUNTY STATE   |   |  |   |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>May 19 84</b> to <b>Jan 27 19 85</b> , that (I) (we) last saw the deceased alive on <b>Jan 23 19 85</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (If (we) did (did not) view the body after death.)                       |  |  |   |  |   |   |  |   |  |  |
| 22b. SIGNATURE <b>Doris M. Hahn MD</b> DEGREE <b>MD</b>   |  |  |   |  | 22c. DATE SIGNED <b>1/28/85</b>   |   |  | 22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>D. M. HAHN</b>   |  |  |
| 22e. ADDRESS <b>5601 Loch Raven Blvd.</b>   |  |  |   |  | 22f. ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |   |  |   |  |  |
| 23a. BURIAL, CREMATION, REMOVAL <b>Burial</b>   |  |  | 23b. DATE <b>1-31-85</b>  |  | 23c. NAME OF CEMETERY OR CREMATORY <b>Baltimore Cem.</b>  |   | 23d. LOCATION CITY OR TOWN COUNTY STATE <b>Balto. Md.</b>                                    |   |  |  |
| 24. FUNERAL DIRECTOR NAME <b>Wm. J. SPICER</b> ADDRESS <b>1639 Broadway</b>   |  |  |   |  | 25a. DATE REC'D. BY REGISTRAR <b>JAN 29 1985</b>  |   | 25b. REGISTRAR'S SIGNATURE <b>Davidson-Randall</b>   |   |  |  |

MEDICAL CERTIFICATION



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

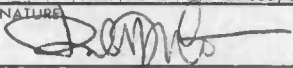
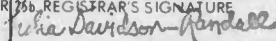
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

Film G599 Item 8  
FOR  
1 - STATE 1/21/85 rja  
REGISTRAR

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 5 0 1 6 3 8

REG. NO.

|   |   |  |   |   |   |
|---|---|--|---|---|---|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>FIRST MIDDLE LAST<br><b>ALBERTO O. TORO</b>  |   |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>1-14-85</b>   |   | 2b. HOUR<br><b>6:30 AM</b>                                    |
| 3. SEX<br><b>Male</b>   | 4. RACE<br><b>White</b>   | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>8/7/1902</b>  |   | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>82</b><br>YRS MONTHS DAYS                           |   |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Puerto Rico</b>   | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore City</b> MD.                         |   |
| 10. CITY OR TOWN OF DEATH<br><b>MD.</b>   | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Mercy Hospital Balto. Md.</b> |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Carpenter</b>            |   | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>Beth Steel</b>        |
| 13a. STATE<br><b>Maryland</b>   | 13b. COUNTY<br><b>---</b>   | 13c. CITY OR TOWN<br><b>Baltimore</b>  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | 13e. STREET ADDRESS<br><b>1258 Battery Ave. Balto. Md. 21230</b>                          |   |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Eusebio O. Tono</b>  |   |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Unknown</b>                                 |   |   |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>No</b>   |   | 16b. SOCIAL SECURITY NO.<br><b>220-20-6556 A</b>   |   | 17. INFORMANT<br>ADDRESS<br><b>Mrs. Isabelle Dieppa, 105 E. West St. 21230 Balto. Md.</b> |   |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Sepsis</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <b>Pneumonia</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <b>Multiple CVA's</b>   |   |  |   |   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>4 days</b> |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <b>---</b>   |   |  |   |   |   |
| 19a. DATE OF OPERATION<br><b>2/9/85</b>   |   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED<br><b>---</b>   |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>      |   |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |   | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>19</b>   |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)            |   |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK  |   | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |   |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>Jan 10, 1985</b> to <b>Jan 14, 1985</b> , that (I) (we) lost<br>saw the deceased alive on <b>Jan 14, 1985</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated<br>above, (I) (we) (did) (did not) view the body after death. |   |  |   |   |   |
| 22b. SIGNATURE<br>   |   | DEGREE<br><b>M.D.</b><br>ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>    |   | 22c. DATE SIGNED<br><b>1/14/85</b>  |   |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>Donald M. Lai</b>   |   | 22e. ADDRESS<br><b>Mercy Hospital</b>  |   |   |   |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>Burial</b>   |   | 23b. DATE<br><b>Jan. 17, 1985</b>  |   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Glen Haven Mem. Park</b>                         |   |
| 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Glen Burnie, A.A. Co. Maryland</b>   |   | 24. FUNERAL DIRECTOR<br>NAME ADDRESS<br><b>McCutty Funeral Home, 130 E. Fort Ave. Balto. Md. 21230</b>   |   |   |   |
| 25a. DATE REC'D. BY REGISTRAR<br><b>JAN 16 1985</b>   |   | 25b. REGISTRAR'S SIGNATURE<br>  |   |   |   |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 2 and 3 should be detached for use as the burial-transit permit. Then please remove carbon copies. Page 2 should be filed with the 24 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, it must be examined and reported on page 4.

MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH  |  |   |                   |  | REG. NO.  |  |
|---|--|---|-------------------|--|---|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>Anna M TRACEY</b>  |  |   | 2a. DATE OF DEATH |  | MONTH DAY YEAR<br><b>1 18 85</b>                              | 2b. HOUR<br><b>5:55 A.M.</b>   |
| 3. SEX<br><b>Female</b>   | 4. RACE<br><b>White</b>  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>1 30 1889</b>  |                   | 6. AGE (IN YEARS (LAST BIRTHDAY))<br><b>95</b>   | IF UNDER 1 YEAR<br>MONTHS DAYS HOURS MIN.<br>IF UNDER 24 HRS. |  |
| 7a. BIRTHPLACE<br>(STATE OR FOREIGN COUNTRY)<br><b>MD</b>   | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>   | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |                   | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Balto. City</b> MD.   |   |  |
| 10. CITY OR TOWN OF DEATH<br><b>Balto.</b>  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>The Wesley Home Inc.</b> |   |                   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK IN MOST OF WORKING LIFE)<br><b>Housewife</b>  |   | 12b. KIND OF BUSINESS OR INDUSTRY  |
| 13a. STATE<br><b>Md.</b>  |  | 13b. CITY OR TOWN<br><b>Balto.</b>  |                   | 13c. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>   |   |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Adam Debaugh</b>   |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Mary Catherine Gray</b>   |                   |  |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)<br><b>No</b>   |  | 16b. SOCIAL SECURITY NO.<br><b>212-24-7968</b>  |                   | 17. INFORMANT ADDRESS<br><b>Mr. Kenneth Bollinger Randallstown, Md.</b>  |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>NATURAL CAUSES</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____                  |  |   |                   |  |   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH   |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <b>Dementia, no congestive heart failure, no stroke</b>  |  |   |                   |  |   |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |                   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>  |   | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |                   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)   |   |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |                   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE  |   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>8/27</b> , 19 <b>78</b> , to <b>1/17</b> , 19 <b>85</b> , that (I) (we) last saw the deceased alive on <b>1/17/85</b> , 19 <b>85</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |  |   |                   |  |   |  |
| 22b. SIGNATURE<br><b>Robert Liberto</b>   |  | DEGREE<br><b>MD</b>   |                   | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> |   | 22c. DATE SIGNED<br><b>1/18/85</b>   |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>ROBERT LIBERTO</b>  |  | 22e. ADDRESS  |                   |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPEC)<br><b>Burial</b>   |  | 23b. DATE<br><b>1/21/85</b>   |                   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Druid Ridge</b>   |   | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Pikesville, Md.</b>   |
| 24. FUNERAL DIRECTOR<br>NAME ADDRESS<br><b>Eline Funeral Home Reisterstown, Md. 21136</b>   |  |   |                   | 25a. DATE REC'D. BY REGISTRAR<br><b>JAN 22 1985</b>  |   | 25b. REGISTRAR'S SIGNATURE<br><b>Davidson-Randall</b>  |

BP





STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

01640

1- FOR  
STATE  
REGISTRAR

REG. NO.

|  |  |                     |  |   |  |   |  |  |  |   |  |   |  |                              |  |
|--|--|---------------------|--|---|--|---|--|--|--|---|--|---|--|------------------------------|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>Nicholas S Transparenti</b>   |  |                     |  |   |  |   |  |  |  | 7a. DATE KNOWN OF DEATH<br>MONTH <b>XX</b> DAY <b>1-17</b> YEAR <b>1985</b> |  | 7b. HOUR<br><b>9:48</b> A.M.  |  |                              |  |
| 3. SEX<br><b>M</b>   |  | 4. RACE<br><b>W</b> |  | 5. DATE OF BIRTH<br>MONTH <b>2</b> DAY <b>17</b> YEAR <b>1969</b>   |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>69</b> YRS. |  | IF UNDER 1 YR.<br>MONTHS <b>0</b> DAYS <b>0</b>  |  | IF UNDER 24 HRS.<br>HOURS <b>0</b> MIN. <b>0</b>                            |  | 7c. DATE PRONOUNCED DEAD<br>MONTH <b>1</b> DAY <b>17</b> YEAR <b>1985</b> |  | 7d. HOUR<br><b>9:48</b> A.M. |  |
| 8. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>MD.</b>   |  |                     |  | 9. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>   |  |   |  | 10. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  |   |  | 11. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore City, MD.</b>       |  |                              |  |
| 12. CITY OR TOWN OF DEATH<br><b>Baltimore</b>  |  |                     |  | 13. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Francis Scott Key Medical Center</b> |  |   |  | 14. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)   |  |   |  | 15. KIND OF BUSINESS OR INDUSTRY<br><b>CITY</b>                           |  |                              |  |
| 16. USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE <b>MD.</b> 13b. COUNTY <b>BALTO</b> 13c. CITY OR TOWN <b>EASTPOINT</b>  |  |                     |  | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  |   |  | 13e. STREET ADDRESS<br><b>21224 7237 GOUGH ST.</b>   |  |   |  |   |  |                              |  |
| 17. FATHER'S NAME<br>FIRST <b>ROCCO</b> MIDDLE <b>TRANSPARENTI</b> LAST <b>TRANSPARENTI</b>  |  |                     |  | 18. MOTHER'S MAIDEN NAME<br>FIRST <b>CORA</b> MIDDLE <b>MALETESTA</b> LAST <b>MALETESTA</b>   |  |   |  | 19. INFORMANT<br><b>LAVRA TRANSPARENTI</b>   |  |   |  | 20. ADDRESS<br><b>A BOVE</b>  |  |                              |  |
| 21. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO, OR UNKNOWN)<br><b>UNK</b>   |  |                     |  | 22. SOCIAL SECURITY NO.<br><b>212013626</b>   |  |   |  | 23. INFORMATION<br><b>LAVRA TRANSPARENTI</b>   |  |   |  | 24. ADDRESS<br><b>A BOVE</b>  |  |                              |  |
| 25. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Arteriosclerotic Cardiovascular Disease</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost.<br>(b)<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c)<br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH                      |  |                     |  |   |  |   |  |  |  |   |  |   |  |                              |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a).  |  |                     |  |   |  |   |  |  |  |   |  |   |  |                              |  |
| 25a. DATE OF OPERATION   |  |                     |  | 25b. CONDITION FOR WHICH OPERATION WAS PERFORMED?   |  |   |  | 25c. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  |   |  |   |  |                              |  |
| 26a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH  |  |                     |  | 26b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>   |  |   |  | 26c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)  |  |   |  |   |  |                              |  |
| 27a. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>   |  |                     |  | 27b. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)   |  |   |  | 27c. LOCATION<br>STREET CITY OR TOWN COUNTY STATE  |  |   |  |   |  |                              |  |
| 28a. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> |  |                     |  |   |  |   |  |  |  |   |  |   |  |                              |  |
| ACTUAL SIGNATURE<br><b>Ann M. Dixon</b>  |  |                     |  | TITLE (SPECIFY)<br><b>Assistant</b>   |  |   |  | DATE SIGNED<br><b>1-18-85</b>  |  |   |  |   |  |                              |  |
| EXAMINER'S NAME (TYPE OR PRINT)<br><b>Ann M. Dixon, M.D.</b>   |  |                     |  | ADDRESS<br><b>111 Penn St., Balto., Md. 21201</b>   |  |   |  |  |  |   |  |   |  |                              |  |
| 29a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>BURIAL</b>   |  |                     |  | 29b. DATE<br><b>1/21/85</b>   |  |   |  | 29c. NAME OF CEMETERY OR CREMATORY<br><b>GARDENS OF FAITH</b>  |  |   |  | 29d. LOCATION<br>CITY OR TOWN <b>BALTO.</b> COUNTY <b>MD.</b> STATE       |  |                              |  |
| 30. FUNERAL DIRECTOR<br>NAME<br><b>J.G. CONNELLY</b>   |  |                     |  | ADDRESS<br><b>300 MALE</b>  |  |   |  | 31. DATE REC'D. BY REGISTRAR<br><b>1 JAN 23 1985</b>   |  |   |  | 32. REGISTRAR'S SIGNATURE   |  |                              |  |

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH. WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 FOR OR TO BURIAL, CREMATION, OR REMOVAL.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

B

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8501641

|  |  |  |  |
|--|--|--|--|
| 1. FOR STATE REGISTRAR   |  | REG. NO.   |  |
| 1. DECEASED NAME (TYPE OR PRINT) <b>Boy</b>  |  | 2a. DATE OF DEATH MONTH <b>1</b> DAY <b>6</b> YEAR <b>85</b> 2b. HOUR <b>9</b> P. M.   |  |
| 3. SEX <b>MALE</b>   | 4. RACE <b>BLACK</b>   | 5. DATE OF BIRTH MONTH <b>1</b> DAY <b>6</b> YEAR <b>85</b>  |  |
| 6. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>MARYLAND</b>   | 7a. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>   | 8. AGE (IN YEARS LAST BIRTHDAY) <b>0</b> YRS. <b>0</b> MONTHS <b>0</b> DAYS <b>0</b> HOURS <b>17</b> MIN.                                    |  |
| 10. CITY OR TOWN OF DEATH <b>BALTIMORE</b>   | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>MERCY HOSPITAL</b> | 9. BALTIMORE CITY OR COUNTY OF DEATH <b>City</b> MD.   |  |
| 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)  |  | 12b. KIND OF BUSINESS OR INDUSTRY  |  |
| 13a. STATE <b>Maryland</b> 13b. COUNTY <b>Dorchester</b> 13c. CITY OR TOWN <b>CAMBRIDGE</b>  |  | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> 13e. STREET ADDRESS <b>1008 Phillips Street</b> |  |
| 14. FATHER'S NAME <b>Unknown</b>   |  | 15. MOTHER'S MAIDEN NAME <b>VERONICA MMT TRAVERS</b>   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, UNKNOWN) <b>No</b>  |  | 16b. SOCIAL SECURITY NO.   |  |
| 17. INFORMANT  |  | ADDRESS  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>CARDIORESPIRATORY Arrest</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>po - VIABILITY</b><br>DUE TO, OR AS A CONSEQUENCE OF (c) <b>Premature delivery</b> |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>17</b><br><b>17</b>   |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)  |  |  |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  |
| 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>   |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>                      |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. <b>19</b>  |  |
| 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)   |  | 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>                                       |  |
| 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE   |  |
| 22a. I certify that (1) (this hospital) attended the deceased from <b>1-6</b> , 19 <b>85</b> , to <b>1-6</b> , 19 <b>85</b> , that (1) (we) last saw the deceased alive on <b>1-6</b> , 19 <b>85</b> , and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (1) (we) (did) (did not) view the body after death.                                  |  |  |  |
| 22b. SIGNATURE <b>Jeffrey Steven Rosenblatt</b> DEGREE   |  | 22c. DATE SIGNED <b>1-6-85</b>   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>JEFFREY STEVEN ROSENBLATT</b>   |  | 22e. ADDRESS <b>MERCY HOSPITAL</b>   |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Removal</b>   |  | 23b. DATE <b>1/10/85</b>   |  |
| 23c. NAME OF CEMETERY OR CREMATORY   |  | 23d. LOCATION CITY OR TOWN COUNTY STATE  |  |
| 24. FUNERAL DIRECTOR NAME <b>Anatomy Board</b>   |  | 25a. DATE REC'D. BY REGISTRAR <b>JAN 17 1985</b> 25b. REGISTRAR'S SIGNATURE <b>Jeffrey Steven Rosenblatt</b>                                 |  |

BP



STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 5 0 1 6 4 2

FOR  
1- STATE  
REGISTRAR

REG. NO.

|  |  |  |  |   |   |  |
|--|--|--|--|---|---|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>FIRST MIDDLE LAST<br><b>SARAH TROTMAN</b>   |  |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>1 16 85</b>  |   | 2b. HOUR<br><b>11:10 PM</b>                     |  |
| 3. SEX<br><b>F</b>   |  | 4. RACE<br><b>B</b>  |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>8 12 44</b>  |   |  |
| 7a. BIRTHPLACE<br>(STATE OR FOREIGN COUNTRY)<br><b>U.S.</b>  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>US</b>                              |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> |   |  |
| 10. CITY OR TOWN OF DEATH<br><b>BALTIMORE</b>  |  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>SINAI HOSP</b> |   |   |  |
| 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>house wife</b>  |  |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>-----0----</b>   |   |   |  |
| 13a. STATE<br><b>MD</b>  |  | 13b. COUNTY<br><b>BALTO</b>  |  | 13c. CITY OR TOWN<br><b>BALTO</b>   |   |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>James V. Johnson</b>  |  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Ellen Weaver</b>   |   |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>0</b>   |  | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)                |  | 17. INFORMANT<br>ADDRESS<br><b>Ellen Johnson, 2843 W. Cold Spring Lane 21215</b>  |   |  |
| 18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c).<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>RESP. FAILURE</b><br>DUE TO, OR AS A CONSEQUENCE OF (b) <b>ARDS</b><br>DUE TO, OR AS A CONSEQUENCE OF (c)<br>PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <b>BREAST CA</b> |  |  |  |   | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                       |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>   |   |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19             |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18. PART 1 OR PART 2)  |   |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>12-27</b> 19 <b>84</b> , to <b>1-16</b> 19 <b>85</b> , that (I) (we) lost<br>saw the deceased alive on <b>1-16</b> 19 <b>85</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated<br>above, (I) (we) (did) (did not) view the body after death.                              |  |  |  |   |   |  |
| 22b. SIGNATURE<br><b>J. Young</b>  |  | DEGREE   |  | 22c. DATE SIGNED  |   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>JOHN YOUNG</b>   |  | 22e. ADDRESS<br><b>SINAI HOSP BALTIMORE</b>                            |  |   |   |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>Burial</b>  |  | 23b. DATE<br><b>1/18/85</b>  |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Mt Auburn Cemetery</b>   |   |  |
| 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Baltimore, Maryland</b>   |  | 23e. DATE REC'D BY REGISTRAR<br><b>JAN 18 1985</b>                     |  |   |   |  |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>Law Funeral Home 4611 Park Heights Ave. 21215</b>   |  | 25. REGISTRAR'S SIGNATURE<br><b>John Davidson-Randall</b>              |  |   |   |  |

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35  
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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 1 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of once.

BP

RECEIVED  
U.S. DEPARTMENT OF AGRICULTURE  
WASHINGTON, D.C.

20% COTTON  
CHELSEA



RECEIVED



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

85501643

FOR  
STATE  
REGISTRAR

REG. NO.

|  |  |   |  |  |  |
|--|--|---|--|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>Bernard L. Tucker   |  |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br>January 19, 1985  |  | 2b. HOUR<br>M                                |
| 3. SEX<br>Male   | 4. RACE<br>Black   | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>11 3 18   | 6. AGE (IN YEARS LAST BIRTHDAY)<br>66 YRS.   | 7. IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS<br>HOURS MIN. |  |
| 7a. BIRTHPLACE<br>COUNTRY<br>MD  | 7b. CITIZEN OF WHAT COUNTRY?<br>USA  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Baltimore City MD.   |  |  |
| 10. CITY OR TOWN OF DEATH<br>Baltimore   | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>1817 Edmondson Avenue |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)   | 12b. KIND OF BUSINESS OR INDUSTRY                                  |  |
| 13a. STATE<br>MD   | 13b. COUNTY  | 13c. CITY OR TOWN<br>Baltimore  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                            | 13e. STREET ADDRESS / ZIP CODE<br>1817 Edmondson Ave. 21223        |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>William R. Tucker  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Lottie Miller  |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) [IF YES, GIVE WAR OR DATES]<br>No   | 16b. SOCIAL SECURITY NO.<br>219-05-0227  | 17. INFORMANT<br>ADDRESS<br>Lottie Tucker 1817 Edmondson Ave.   |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) Cardio pulmonary arrest<br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) CA of Larynx<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c)<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. |  |   |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:   |  |   |  |  |  |
| 19a. DATE OF OPERATION   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>   | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)  |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK   | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from 9-6-85, to 1-8-85, that (I) (we) last saw the deceased alive on 1-8-85, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.  |  |   |  |  |  |
| 22b. SIGNATURE<br>Robert L. Smith MD   | DEGREE<br>MD   | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>                  | 22c. DATE SIGNED<br>1-22-85  |  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>Robert L. Smith MD  |  | 22e. ADDRESS<br>GBMC Hospital   |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(TYPE)<br>Burial  | 23b. DATE<br>1/23/85   | 23c. NAME OF CEMETERY OR CREMATORY<br>Mt. Auburn Cem.   | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Baltimore MD   |  |  |
| 24. FUNERAL DIRECTOR<br>NAME<br>Wm. C. March F/H 1101 E. North Ave.  |  | 25a. DATE REC'D. BY REGISTRAR<br>JAN 23 1985  |  |  |  |
|  |  | 25b. REGISTRAR'S SIGNATURE<br>John Davidson-Ronder  |  |  |  |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 shall be filled within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, it must be reported to the State Department of Health and Mental Hygiene.

## MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH  |  |   |  | 8 5 0 1 6 4 4  |  |   |  |
|---|--|---|--|--|--|---|--|
| 1. FOR STATE REGISTRAR  |  |   |  | REG. NO.   |  |   |  |
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>SEBASTINE TUCKER</b>   |  |   |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR <b>1-23-85</b> 2b. HOUR <b>12:33 AM</b>  |  |   |  |
| 3. SEX <b>F</b>   |  | 4. RACE <b>W</b>  |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR <b>10/14/21</b>   |  | 6. AGE (IN YEARS LAST BIRTHDAY) <b>63</b> YRS. IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.                  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>MD.</b>  |  | 7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>   |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH <b>BALTO. CITY MD.</b>   |  |
| 10. CITY OR TOWN OF DEATH <b>BALTO</b>  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>F.S. KEY MED. CENT.</b> |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>H.S.W.E.</b>  |  | 12b. KIND OF BUSINESS OR INDUSTRY   |  |
| 13a. STATE <b>MD</b> 13b. COUNTY <b>BALTO</b> 13c. CITY OR TOWN <b>SPARROWS PT</b>  |  |   |  | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  | 13e. STREET ADDRESS / ZIP CODE <b>3 TURTLE CT 21219</b>   |  |
| 14. FATHER'S NAME FIRST MIDDLE LAST <b>ROSARIO BARBARINO</b>  |  |   |  | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>UNK</b>  |  |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>NO</b>   |  | 16b. SOCIAL SECURITY NO. <b>UNK</b>   |  | 17. INFORMANT ADDRESS <b>217 KATHLEEN SUPER SHA5 GARK RD</b>   |  |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>cardiac arrest</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <b>myocardial infarction</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <b>coronary artery disease</b> |  |   |  |  |  |   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2. OTHER SIGNIFICANT CONDITIONS <u>CONTRIBUTING TO DEATH</u> BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)  |  |   |  |  |  |   |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>   |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. <b>19</b>   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)   |  |   |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK  |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE   |  |   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>1/17</b> 19 <b>85</b> , to <b>1/23</b> 19 <b>85</b> , that (I) (we) last saw the deceased alive on <b>1/23</b> 19 <b>85</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) did (did not) view the body after death.  |  |   |  |  |  |   |  |
| 22b. SIGNATURE <b>Charles B. Treasure</b> DEGREE  |  |   |  | 22c. DATE SIGNED <b>1/23/85</b>  |  |   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>Charles B. Treasure</b>  |  |   |  | 22e. ADDRESS <b>Francis Scott Key Hospital Balto, MD</b>   |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>BURIAL</b>   |  | 23b. DATE <b>1/26/85</b>  |  | 23c. NAME OF CEMETERY OR CREMATORY <b>HOLLY HILL</b>   |  | 23d. LOCATION CITY OR TOWN COUNTY STATE <b>BALTO. MD</b>  |  |
| 24. FUNERAL DIRECTOR NAME <b>J.G. CONNELLY</b> ADDRESS <b>300 MACE</b>  |  |   |  | 25a. DATE REC'D. BY REGISTRAR <b>JAN 30 1985</b>   |  | 25b. REGISTRAR'S SIGNATURE <b>Davidson-Randall</b>  |  |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

FOR  
STATE  
REGISTRAR

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 5 0 1 6 4 5

REG. NO.

|   |  |  |   |   |                            |  |
|---|--|--|---|---|----------------------------|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>FIRST MIDDLE LAST<br><b>Morris Espey Tuel</b>  |  |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>January 2, 1985</b> |   | 2b. HOUR<br>M<br><b>AM</b> |  |
| 3. SEX<br><b>Male</b>   |  | 4. RACE<br><b>Caucasian</b>  |   | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>2 23 1911</b>  |                            |  |
| 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>73</b> YRS  |  | 7a. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>   |   | 7b. IF UNDER 1 YEAR<br>MONTHS DAYS<br><b>73</b>   |                            |  |
| 8. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Maryland</b>   |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore City</b>  |   | 9. MD.  |                            |  |
| 10. CITY OR TOWN OF DEATH<br><b>Baltimore</b>   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>St. Agnes Hospital</b>   |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Salesman</b>                           |                            |  |
| 12b. KIND OF BUSINESS OR INDUSTRY<br><b>Hardware</b>  |  | 13a. STATE<br><b>Maryland</b>  |   | 13b. COUNTY<br><b>Baltimore</b>   |                            |  |
| 13c. CITY OR TOWN<br><b>Baltimore</b>   |  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |   | 13e. STREET ADDRESS / ZIP CODE<br><b>332 Westshire Rd. 21229</b>  |                            |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Peter Tuel</b>   |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Susan B. Espey</b>   |   | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)<br><b>no</b> |                            |  |
| 16b. SOCIAL SECURITY NO.<br><b>218-01-9902</b>  |  | 17. INFORMANT<br><b>Albert J. Tuel</b>   |   | 18. ADDRESS<br><b>332 Westshire Rd. Balto., Md. 21229</b>   |                            |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Electromechanical dissociation</b><br>DUE TO, OR AS A CONSEQUENCE OF (b) <b>presumed pulmonary embolism</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) <b>CHF</b><br>PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <b>CHF, COPD.</b> |  |  |   |   |                            |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>                                     |                            |  |
| 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>  |  | 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER NOTIFY MEDICAL EXAMINER)   |   | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>19</b>  |                            |  |
| 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |  | 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK   |   | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |                            |  |
| 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  | 22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (in (we) (did) not view the body after death. |   |   |                            |  |
| 22b. SIGNATURE<br><b>Joseph Adams, M.D.</b>   |  | 22c. DATE SIGNED<br><b>1/2/85</b>  |   | 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>Joseph Adams, M.D.</b>  |                            |  |
| 22e. ADDRESS<br><b>4940 Eastern Ave. Balto., Md. 21224</b>  |  | 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>Burial</b>  |   | 23b. DATE<br><b>1/4/85</b>  |                            |  |
| 23c. NAME OF CEMETERY OR CREMATORY<br><b>Loudon Park Cem.</b>   |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Baltimore City, Maryland</b>  |   | 24. FUNERAL DIRECTOR<br>NAME ADDRESS<br><b>MacNabb Funeral Home Catonsville, Md.</b>                          |                            |  |
| 25a. DATE REC'D. BY REGISTRAR<br><b>JAN 3 1985</b>  |  | 25b. REGISTRAR'S SIGNATURE<br><b>[Signature]</b>   |   |   |                            |  |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner may be notified by page 3.STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 5 0 1 6 4 6

1- FOR  
STATE  
REGISTRAR

REG. NO.

|  |  |  |  |   |   |  |  |  |  |  |
|--|--|--|--|---|---|--|--|--|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>FIRST MIDDLE LAST<br><b>HELEN MARGARET TUMA</b>   |  |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>JAN. 12, 1985</b>            |   | 2b. HOUR<br><b>1:34AM</b>   |  |  |  |  |  |
| 3. SEX<br><b>Female</b>  |  | 4. RACE<br><b>Cauc.</b>  |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>9/1/13</b>   |   | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>71</b> YRS.<br>IF UNDER 1 YEAR: MONTHS DAYS<br>IF UNDER 24 HRS: HOURS MIN.                           |  |  |  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Balto.</b>   |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>BALTIMORE CITY</b> MD.  |  |  |  |  |
| 10. CITY OR TOWN OF DEATH<br><b>BALTIMORE</b>  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>JOHNS HOPKINS HOSPITAL</b> |  |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Packager</b> |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>Goetze Candy Company</b> |  |  |  |
| 13a. STATE<br><b>Md.</b>   |  | 13b. COUNTY<br><b>-</b>  |  | 13c. CITY OR TOWN<br><b>Balto.</b>  |   | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>  |  | 13e. STREET ADDRESS / ZIP CODE<br><b>608N. Belnord Ave. 21205</b>  |  |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Unknown</b>   |  |  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Unknown</b>   |   |  |  |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>No</b>  |  | 16b. SOCIAL SECURITY NO.<br><b>214-38-8650</b>   |  | 17. INFORMANT<br>ADDRESS<br><b>21234 Marie Kurrupis, 8522 Chestnut Oak Rd.</b>  |   |  |  |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>CHRONIC AND RESPIRATORY ARREST</b><br>DUE TO, OR AS A CONSEQUENCE OF (b) _____<br>DUE TO, OR AS A CONSEQUENCE OF (c) _____<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: _____ |  |  |  |   |   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>ONE HOUR</b>  |  |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)<br><b>HYPERTENSION, DIABETES</b>  |  |  |  |   |   |  |  |  |  |  |
| 19a. DATE OF OPERATION   |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                       |   |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19             |   |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)   |  |  |  |  |
| 21d. INJURY OCCURRED<br>WHERE <input type="checkbox"/> NOT WHERE <input type="checkbox"/><br>AT WORK AT WORK   |  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) |   |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE  |  |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>8/1/12</b> , 19 <b>85</b> , to <b>1/12</b> , 19 <b>85</b> , that (I) (we) last saw the deceased alive on <b>1/12</b> , 19 <b>85</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.   |  |  |  |   |   |  |  |  |  |  |
| 22b. SIGNATURE<br><b>James S. Greenwald</b>  |  |  | DEGREE<br><b>MD, PhD</b>   |   |   | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> |  | 22c. DATE SIGNED<br><b>1/12/85</b>   |  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)  |  |  | 22e. ADDRESS   |   |   |  |  |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>Burial</b>  |  |  | 23b. DATE<br><b>1/15/85</b>  |   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Holy Redeemer</b>                          |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Balto., Md.</b> |  |  |  |
| 24. FUNERAL HOME, INC.<br>3331 Brehms Lane, Balto., Md. 21213  |  |  |  |   |   | 25a. DATE REC'D. BY REGISTRAR<br><b>JAN 14 1985</b>  |  |  | 25b. REGISTRAR'S SIGNATURE<br><b>Julia Davidson-Pond</b> |  |

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STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8501647

FOR  
1 - STATE  
REGISTRAR

REG. NO.

|   |  |  |   |  |                             |   |  |
|---|--|--|---|--|-----------------------------|---|--|
| 1 DECEASED NAME<br>(TYPE OR PRINT)<br>FIRST MIDDLE LAST<br><b>CHARLES L. TURNER SR.</b>                       |  |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>JANUARY 9, 1985</b> |  | 2b. HOUR A<br><b>2:35 M</b> |   |  |
| 3 SEX<br><b>Male</b>  |  | 4. RACE<br><b>Black</b>  |   | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>2 12 12</b>   |                             | 6. AGE (IN YEARS LAST BIRTHDAY)<br>YRS.<br><b>72</b>  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>N.C.</b>  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>   |   | 8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |                             | 9 BALTIMORE CITY OR COUNTY OF DEATH<br><b>BALTIMORE CITY</b> MD.                                |  |
| 10 CITY OR TOWN OF DEATH<br><b>BALTIMORE</b>  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>THE JOHNS HOPKINS HOSPITAL</b> |   |  |                             | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)                                |  |
| 13a. STATE<br><b>MD</b>   |  | 13b. COUNTY  |   | 13c. CITY OR TOWN<br><b>Baltimore</b>  |                             | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |
| 14 FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Isaac Turner</b>  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Sarah</b>  |   | 17. ADDRESS<br><b>3028 Acension St. 21225</b>  |                             |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)<br><b>No</b> |  | 16b. SOCIAL SECURITY NO.<br><b>217-09-3727</b>   |   | 17 INFORMANT<br><b>Tyrone Turner</b>   |                             |   |  |

18 CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)  
PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a)

*Cardio pulmonary Arrest*APPROXIMATE INTERVAL  
BETWEEN ONSET AND DEATH*30 minutes*

DUE TO, OR AS A CONSEQUENCE OF

(b)

*metabolic Encephalopathy*

DUE TO, OR AS A CONSEQUENCE OF

(c)

*Renal failure, pneumonia*

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)

*Pneumonia, Prosthetic tumor.*

|  |  |   |  |  |  |   |  |
|--|--|---|--|--|--|---|--|
| 19a. DATE OF OPERATION<br><b>12/13/84</b>  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED<br><b>Pne.</b>   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>                  |  | 20b. IF YES, WERE FINDINGS USED<br>IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b> |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)              |  |   |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>  |  | 21e. PLACE OF INJURY<br>(AT HOME STREET FACTORY OFFICE FARM ETC.) |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE  |  |   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>12/12</b> , 19 <b>84</b> , to <b>1/9/85</b> , 19 <b>85</b> , that (I) (we) last saw the deceased alive on <b>1/9</b> , 19 <b>85</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |  |   |  |  |  |   |  |
| 22b. SIGNATURE<br><i>Paul Lee MD</i>   |  |   |  | DEGREE<br><b>MD</b>  |  | 22c. DATE SIGNED<br><b>1/9/85</b>   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>PAUL LEE MD</b>  |  |   |  | 22e. ADDRESS<br><b>600 N. WOLFE ST. BALTO. MD.</b><br><i>Johns Hopkins Hospital. 21205</i> |  |   |  |

|   |  |                             |  |  |  |   |  |
|---|--|-----------------------------|--|--|--|---|--|
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>Burial</b> |  | 23b. DATE<br><b>1/12/85</b> |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>King Mem. Pk.</b> |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Baltimore Co. MD</b> |  |
| 24 FUNERAL DIRECTOR<br>NAME<br><b>Wm. C. March F/H</b>        |  |                             |  | ADDRESS<br><b>1101 E. North Ave.</b>                       |  | 25a. DATE REC'D. BY REGISTRAR<br><b>JAN 10 1985</b>                   |  |
|   |  |                             |  | 25b. REGISTRAR'S SIGNATURE<br><i>W. C. March</i>           |  |   |  |

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STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 5 0 1 6 4 8

1- FOR  
STATE  
REGISTRAR

REG. NO.

|  |  |  |   |  |  |   |  |  |  |  |  |   |  |  |   |  |  |
|--|--|--|---|--|--|---|--|--|--|--|--|---|--|--|---|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br><b>BESSIE</b>   |  |  | FIRST MIDDLE LAST<br><b>TURNER</b>  |  |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>1 4 85</b>  |  |  | 2b. HOUR<br><b>11 AM</b>   |  |  |   |  |  |   |  |  |
| 3. SEX<br><b>Female</b>  |  |  | 4. RACE<br><b>Black</b>   |  |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>11 27 96</b>   |  |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>88</b> YRS.                          |  |  |   |  |  |   |  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>N. Carolina</b>  |  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>   |  |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore City</b> MD.          |  |  |   |  |  |   |  |  |
| 10. CITY OR TOWN OF DEATH<br><b>Baltimore</b>  |  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>J. L. DEATON MEDICAL CENTER</b> |  |  |   |  |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)           |  |  | 12b. KIND OF BUSINESS OR INDUSTRY   |  |  |   |  |  |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE<br><b>Maryland</b>  |  |  |   |  |  | 13b. COUNTY   |  |  | 13c. CITY OR TOWN<br><b>Baltimore</b>                                      |  |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |  | 13e. STREET ADDRESS / ZIP CODE<br><b>2504 Loyola Southway 21215</b> |  |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Horace Franklin</b>   |  |  |   |  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Phyllis Harris</b>  |  |  |  |  |  |   |  |  |   |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>NO</b>  |  |  |   |  |  | 16b. SOCIAL SECURITY NO.<br><b>244-28-0836</b>  |  |  | 17. INFORMANT<br>ADDRESS<br><b>Celestine Townsend 2504 Loyola Southway</b> |  |  |   |  |  |   |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Hyperosmolar Nonketotic Coma.</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <b>Diabetes Mellitus</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. |  |  |   |  |  |   |  |  |  |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH  |  |  |   |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: (a)<br><b>Cerebrovascular disease; multi-infarct dementia; decubitus ulcers; renal insufficiency.</b>   |  |  |   |  |  |   |  |  |  |  |  |   |  |  |   |  |  |
| 19a. DATE OF OPERATION   |  |  |   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                       |  |   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>  |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |   |  |  |   |  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  |  |   | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19             |  |   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18: PART I OR PART 2)   |  |  |  |   |  |  |   |  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK   |  |  |   | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) |  |   |  | 21f. LOCATION<br>STREET  |  | CITY OR TOWN   |  | COUNTY STATE  |  |  |   |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>Dec 10</b> 19 <b>84</b> , to <b>Jan 4</b> 19 <b>85</b> , that (I) (we) last saw the deceased alive on <b>Jan 4</b> 19 <b>85</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.                         |  |  |   |  |  |   |  |  |  |  |  |   |  |  |   |  |  |
| 22b. SIGNATURE<br><b>George Taler, M.D.</b>  |  |  |   | DEGREE   |  |   |  | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |  | 22c. DATE SIGNED<br><b>Jan 4, 1985</b>   |  |   |  |  |   |  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>George Taler, M.D.</b>   |  |  |   | 22e. ADDRESS<br><b>680 Light St. Balt. Md. 21230</b>                   |  |   |  |  |  |  |  |   |  |  |   |  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(CHECK)<br><b>BURIAL</b>  |  |  |   | 23b. DATE<br><b>1/9/85</b>   |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Arbutus Memorial Pk.</b>   |  |  |  | 23d. LOCATION<br>CITY OR TOWN  |  | COUNTY STATE<br><b>Arbutus, Md.</b>   |  |  |   |  |  |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>Wm C March F/H Inc.</b>   |  |  |   |  |  | ADDRESS<br><b>1101 E North Avenue</b>   |  | 25a. DATE REC'D. BY REGISTRAR<br><b>JAN 7 1985</b>   |  | 25b. REGISTRAR'S SIGNATURE<br><b>Davidson-Randall</b>  |  |   |  |  |   |  |  |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.



TO HOSPITAL OR ATTENDING PHYSICIAN. The law requires that the death certificate be executed within 24 hours after death. Page 4 may be returned by the hospital or attending physician.

TO FUNERAL DIRECTOR. After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 1 and 2 should be detached for use at the burial-transit permit. Then please remove carbon copies. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

85 01649

FOR  
1. STATE  
REGISTRAR

REG. NO.

|  |  |   |   |   |  |   |  |
|--|--|---|---|---|--|---|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>VERLEEN L. TURNER   |  |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br>1 8 85 |   |  | 2b. HOUR<br>5 30 A.M.   |  |
| 3. SEX<br>Female   |  | 4. RACE<br>Black  |   | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>8 11 1913   |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br>71 YRS.  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>VIRGINIA  |  | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.A.  |   | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>BALTIMORE CITY MD.                                      |  |
| 10. CITY OR TOWN OF DEATH<br>BALTIMORE   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>BON SECOURS HOSPITAL |   |   |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Domestic                    |  |
| 12b. KIND OF BUSINESS OR INDUSTRY<br>Private   |  |   |   |   |  |   |  |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>MD.  |  | 13b. COUNTY<br>BALTIMORE  |   | 13c. CITY OR TOWN<br>BALTIMORE  |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |
| 13e. STREET ADDRESS / ZIP CODE<br>1503 ARGYLE AVE. 21217   |  |   |   |   |  |   |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>WILLIE LOMAX   |  |   |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>MARSHA HARRIS  |  |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br>No   |  | 16b. SOCIAL SECURITY NO.<br>214-18-0592   |   | 17. INFORMANT<br>ADDRESS<br>Delores Massey 1503 Argyle Ave.   |  |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) Chock<br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (b), stating the underlying cause last.<br>(b) Bleeding from stomach<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) Cancer of stomach |  |   |   |   |  |   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH   |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)  |  |   |   |   |  |   |  |
| 19a. DATE OF OPERATION<br>12/27/84   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED<br>Gastric Bleeding  |   |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |   | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |  |   |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |   |  |
| 22a. I certify that (this hospital) attended the deceased from Nov. 26 84 to Jan 8 85, that (we) last saw the deceased alive on Jan 8 85, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (we) (did) (did not) view the body after death.   |  |   |   |   |  |   |  |
| 22b. SIGNATURE<br>A. ZALDUENDO   |  | DEGREE<br>MD  |   | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>                  |  | 22c. DATE SIGNED<br>1/8/85  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>A. ZALDUENDO  |  | 22e. ADDRESS  |   |   |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br>Burial  |  | 23b. DATE<br>1-14-85  |   | 23c. NAME OF CEMETERY OR CREMATORY<br>Arbutus Mem. PK.  |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Arbutus MD.                                       |  |
| 24. FUNERAL DIRECTOR<br>NAME<br>Randolph J. Collick  |  | ADDRESS<br>2431 E. Oliver St.   |   | 25a. DATE REC'D. BY REGISTRAR<br>JAN 9 1985   |  | 25b. REGISTRAR'S SIGNATURE<br>John Davidson-Randell   |  |

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STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8501650

1- FOR  
STATE  
REGISTRAR

REG. NO.

|   |  |  |  |   |   |
|---|--|--|--|---|---|
| 1 DECEASED NAME<br>(TYPE OR PRINT) <b>William Henry Turner</b>  |  |  | 2a. DATE OF DEATH MONTH DAY YEAR<br><b>01-06-85</b>                                |   | 2b. HOUR<br><b>8<sup>57</sup> A.M.</b>    |
| 3. SEX<br><b>M</b>  | 4 RACE<br><b>B</b>   | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>09-01-1894</b>  | 6 AGE (IN YEARS LAST BIRTHDAY)<br><b>90</b>  |   | IF UNDER 1 YEAR<br>MONTHS DAYS HOURS MIN. |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>MD</b>  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>  | 8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 9 BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore City</b> MD.                   |   |   |
| 10 CITY OR TOWN OF DEATH<br><b>Balto.</b>   | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Univ. of Md. Hosp.</b> |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK OR MOST OF WORKING LIFE)<br><b>Cyberman</b> |   | 12b. KIND OF BUSINESS OR INDUSTRY         |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13b. STATE<br><b>MD</b> |  |  | 13c. CITY OR TOWN<br><b>ANNAPOLIS</b>  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |   |
| 14. FATHER'S NAME<br>FIRST LAST<br><b>John Henry Turner</b>   |  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Sallye Dennis</b>              |   |   |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>yes</b>                                      |  |  | 16b. SOCIAL SECURITY NO.<br><b>219-12-273</b>                                      |   |   |
| 17. INFORMANT<br><b>Century Nursing Home</b>  |  |  | ADDRESS<br><b>-102 N. Paca St, Balto, MD</b>                                       |   |   |

18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)  
PART I. DEATH WAS CAUSED BY

IMMEDIATE CAUSE (a) **cardiac arrest**

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last

(b) **possibly** **gastrointestinal hemorrhage**

(c) **unk.**

APPROXIMATE INTERVAL  
BETWEEN ONSET AND DEATH  
**~ 1-2 hr.**

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)

**no other medical history available**

|   |  |  |  |   |  |
|---|--|--|--|---|--|
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                       |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>      | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) |   |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                              |   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>1/26/1985</b> to <b>1/26/1985</b> , that (I) (we) last saw the deceased alive on <b>1/26/1985</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (If (we) (did) (did not) view the body after death.) |  |  |  |   |  |
| 22b. SIGNATURE<br><b>Robie Suh</b>  |  | DEGREE<br><b>M.D.</b>  |  | 22c. DATE SIGNED<br><b>1/26/85</b>  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>Robie - Suh MD</b>  |  | 22e. ADDRESS<br><b>Univ. of Md. Hosp. Balto MD</b>                     |  |   |  |

|  |                               |   |  |
|--|-------------------------------|---|--|
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>Burial</b> | 23b. DATE<br><b>1-30-1985</b> | 23c. NAME OF CEMETERY OR CREMATORY<br><b>MD VA Cemetery</b> | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Crownsville A.A. MD</b> |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>C. B. Hicks III</b>     |                               | 25a. DATE REC'D. BY REGISTRAR<br><b>FEB 07 1985</b>         |  |
| ADDRESS<br><b>1922 Forest Drive</b>                        |                               | 25b. REGISTRAR'S SIGNATURE<br><b>John Davidson-Randall</b>  |  |

BP \_\_\_\_\_

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.





STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 5 0 1 6 5

1 - FOR  
STATE  
REGISTRAR

REG. NO.

|  |  |   |  |   |  |   |  |  |  |
|--|--|---|--|---|--|---|--|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)  |  | FIRST MIDDLE LAST   |  | 2. DATE OF DEATH  |  | MONTH DAY YEAR  |  | 2b. HOUR                                     |  |
| XXXXX BETTY W XXXXX TUTEN  |  |   |  | JANUARY 25, 1985  |  |   |  | 2:05 p.m.                                    |  |
| 3. SEX   |  | 4. RACE   |  | 5. DATE OF BIRTH  |  | 6. AGE (IN YEARS LAST BIRTHDAY)   |  | 7. IF UNDER 1 YEAR                           |  |
| F  |  | B   |  | MONTH DAY YEAR<br>12 14 04  |  | 80 YRS  |  | IF UNDER 1 YEAR<br>MONTHS DAYS HOURS MIN.    |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)  |  | 7b. CITIZEN OF WHAT COUNTRY?  |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH  |  |  |  |
| Ayrone, NC   |  | USA   |  |   |  | Baltimore City  |  | MD.  |  |
| 10. CITY OR TOWN OF DEATH  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)  |  | 12b. KIND OF BUSINESS OR INDUSTRY   |  |  |  |
| Baltimore  |  | CHURCH HOSPITAL   |  | HOME MAKER  |  | AT HOME   |  |  |  |
| 13a. STATE   |  | 13b. COUNTY   |  | 13c. CITY OR TOWN   |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 13e. STREET ADDRESS / ZIP CODE               |  |
| MD   |  |   |  | Baltimore   |  |   |  | 1623 W. Mulberry St                          |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST   |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST   |  |   |  |   |  |  |  |
| Lode Williams  |  | JENNIE BURLY  |  |   |  |   |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)   |  | 16b. SOCIAL SECURITY NO.  |  | 17. INFORMANT   |  | ADDRESS   |  |  |  |
| NO   |  | 242-14-6748   |  | JENNIE WALKINS  |  | 1623 W. MULBERRY ST   |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>CARDIO RESPIRATORY ARREST, OLD C.V.A.</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <u>BILATERAL LOWER LOBE PNEUMONIA</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. |  |   |  |   |  |   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)   |  |   |  |   |  |   |  |  |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |   | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |  |   |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                                    |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |   |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>JANUARY 23, 19 85</u> , to <u>JANUARY 25, 19 85</u> , that (I) (we) last saw the deceased alive on <u>JANUARY 25, 19 85</u> , and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) did (did not) view the body after death.   |  |   |  |   |  |   |  |  |  |
| 22b. SIGNATURE<br>WALKER, DR. PASCIALE   |  |   |  | DEGREE  |  |   | 22c. DATE SIGNED<br>1/25/85  |  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)  |  |   |  | 22e. ADDRESS<br>CHURCH HOSPITAL CORPORATION<br>100 NORTH BROADWAY BALTO., MD. 21231   |  |   |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)   |  | 23b. DATE   |  | 23c. NAME OF CEMETERY OR CREMATORY  |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE  |  |  |  |
| Removal  |  | 1/28/84   |  | Bannock   |  | Baltimore City  |  |  |  |
| 24. FUNERAL DIRECTOR<br>NAME ADDRESS   |  |   |  | 25a. DATE REC'D BY REGISTRAR  |  | 25b. REGISTRAR'S SIGNATURE  |  |  |  |
| Marshall & Hughes 638 N. 1st St  |  |   |  | JAN 28 1985   |  | J. J. J. J.   |  |  |  |

93814 10101 61863

WILSON



STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 5 0 1 6 5 2

FOR  
STATE  
REGISTRAR

REG. NO.

|   |  |  |   |   |  |  |  |   |  |
|---|--|--|---|---|--|--|--|---|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br><i>Henry Tuten Jr.</i>   |  |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><i>Jan. 29, 1985</i> |   |  | 2b. HOUR<br>M<br><i>M</i>  |  |   |  |
| 3. SEX<br><i>Male</i>   |  | 4. RACE<br><i>White</i>  |   | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><i>9-17-1914</i>  |  | 6. AGE (IN YEARS) (LAST BIRTHDAY)<br>YRS. MONTHS DAYS HOURS MIN.<br><i>70</i>              |  |   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><i>North Carolina</i>  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><i>U.S.A.</i>  |   | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><i>Baltimore City</i> MD.                          |  |   |  |
| 10. CITY OR TOWN OF DEATH<br><i>Balto. Md.</i>  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><i>6129 Ridgeview Ave. -21206</i> |   |   |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><i>Marine Industry</i> |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><i>McLean Bros.</i>        |  |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE <i>Md.</i> 13b. COUNTY <i>Balto.</i> 13c. CITY OR TOWN <i>Balto.</i> 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> 13e. STREET ADDRESS / ZIP CODE <i>6129 Ridgeview Ave. -21206</i>   |  |  |   |   |  |  |  |   |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><i>Henry Tuten Sr.</i>  |  |  |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><i>Lelia E. Spruill</i>  |  |  |  |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><i>No</i>   |  | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br><i>240-14-3695</i>  |   | 17. INFORMANT ADDRESS<br><i>Mrs. Alice Jones Tuten 6129 Ridgeview Ave. 21206</i>  |  |  |  |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <i>respiratory failure</i><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <i>hepatic encephalopathy</i><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c)<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <i>sev. years</i>  |  |  |   |   |  |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><i>Few days</i> |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)   |  |  |   |   |  |  |  |   |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |   |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |   |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><i>P.M. 19</i>  |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)  |  |  |  |   |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE<br><i>9 E. Chase St. Balto. Md.</i>   |  |  |  |   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <i>1-29</i> , 19 <i>85</i> , to <i>present</i> , that (I) <input checked="" type="checkbox"/> saw the deceased alive on <i>1-15</i> , 19 <i>85</i> , and that in (my) <input checked="" type="checkbox"/> opinion death occurred on the date and hour and from the causes stated above, (I) <input checked="" type="checkbox"/> (did not) view the body after death. |  |  |   |   |  |  |  |   |  |
| 22b. SIGNATURE<br><i>Dr. Philip Ngle</i>  |  |  |   | DEGREE<br><i>M.D.</i>   |  |  | 22c. DATE SIGNED<br><i>1-30-85</i>   |   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><i>Philip Wagley</i>   |  |  |   | 22e. ADDRESS<br><i>9 E. Chase St. 21202</i>   |  |  |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><i>Cremation</i>  |  | 23b. DATE<br><i>1-30-85</i>  |   | 23c. NAME OF CEMETERY OR CREMATORY<br><i>Greenmount Crematory</i>   |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><i>Balto. Md.</i>                            |  |   |  |
| 24. FUNERAL DIRECTOR<br>NAME<br><i>John C. Miller Inc-415 Belair Rd.-21206</i>  |  |  |   | 25. DATE REC'D. BY REGISTRAR<br>FEB 4 1985  |  |  |  |   |  |
|   |  |  |   | 25. REGISTRAR'S SIGNATURE<br><i>Gaila Davidson-Randall</i>  |  |  |  |   |  |

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

1. 1992

54-1-

| Age Group | Percentage |
|-----------|------------|
| 18-24     | ~15%       |
| 25-34     | ~35%       |
| 35-44     | ~55%       |
| 45-54     | ~70%       |
| 55-64     | ~80%       |
| 65+       | ~85%       |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH   |  |   |  | REG. NO.  |  |  |  |
|--|--|---|--|---|--|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>FIRST MIDDLE LAST<br><b>VIRGINIA B. TWEEDY</b>  |  |   |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>1-23-85</b>   |  |  |  |
| 3. SEX<br><b>Female</b>  |  | 4. RACE<br><b>White</b>   |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>Dec. 16, 1901</b>  |  | 2b. HOUR<br><b>2 P</b> M   |  |
| 7a. BIRTHPLACE<br>(STATE OR FOREIGN COUNTRY)<br><b>VA</b>  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>  |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br>YRS.<br><b>83</b>  |  | IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS.<br>HOURS MIN.   |  |
| 10. CITY OR TOWN OF DEATH<br><b>Baltimore</b>  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Union Memorial Hospital</b> |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>       |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore City</b> MD.  |  |
| 12a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE<br><b>MD</b>  |  | 13b. COUNTY<br><b>BALTO</b>   |  | 13c. CITY OR TOWN<br><b>Balto.</b>  |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                            |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Jacob Edward Baker</b>  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Mary Willis</b>   |  | 12b. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Homemaker</b>  |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>No</b>  |  | 16b. SOCIAL SECURITY NO.<br><b>217 26 4136</b>  |  | 17. INFORMANT<br>ADDRESS<br><b>Virginia T. Nufer, Danville, VA</b>  |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Acute MI</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(b) <b>ASCVD</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c)                  |  |   |  |   |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a   |  |   |  |   |  |  |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  | 20a. AUTOPSY?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>  |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)  |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>1-15</b> , 19 <b>85</b> , to <b>1-23</b> , 19 <b>85</b> , that (I) (we) last saw the deceased alive on <b>1-23</b> , 19 <b>85</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |  |   |  |   |  |  |  |
| 22b. SIGNATURE<br><b>Scott Gersh</b>   |  |   |  | DEGREE<br><b>MD</b><br>ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> |  | 22c. DATE SIGNED<br><b>1-23-85</b>   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>SCOTT GERSH MD</b>   |  |   |  | 22e. ADDRESS<br><b>UNION MEMORIAL HOSPITAL</b>  |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>Cremation</b>   |  | 23b. DATE<br><b>1/24/85</b>   |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Green Mount</b>  |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Balto., MD</b>  |  |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>Henry W. Jenkins &amp; Sons Co.</b><br>ADDRESS<br><b>4905 York Road Balto., MD 21212</b>  |  |   |  | 25a. DATE REC'D. BY REGISTRAR<br><b>JAN 25 1985</b><br>25b. REGISTRAR'S SIGNATURE<br><b>[Signature]</b>   |  |  |  |

20% COTTON FIB

CHINESE



Green Mount  
Henry W. Jenkins & Sons Co.  
NEOS York Road, Md. 21215

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STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|   |   |   |   |  |   |  |   |   |
|---|---|---|---|--|---|--|---|---|
| 1. DECEASED NAME<br>(TYPE OR PRINT)   |   |   | 2a. DATE OF DEATH   |  |   | 2b. HOUR   |   |   |
| FIRST<br>CATHERINE  | MIDDLE<br>ANN   | LAST<br>TYLER   | MONTH DAY YEAR<br>1 17 85   |  |   | 8:31A.M.   |   |   |
| 3. SEX<br>FEMALE  | 4. RACE<br>WHITE  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>03 06 12  | 6. AGE (IN YEARS LAST BIRTHDAY)<br>72 YRS.  |  |   | IF UNDER 1 YEAR<br>MONTHS DAYS HOURS MIN.  |   |   |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>MARYLAND   | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.A.  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>BALTIMORE CITY MD.                                      |  |   |  |   |   |
| 10. CITY OR TOWN OF DEATH<br>BALTIMORE  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>ST. AGNES HOSPITAL |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>HOMEMAKER                   |  |   | 12b. KIND OF BUSINESS OR INDUSTRY<br>---   |   |   |
| 13a. STATE<br>MARYLAND  |   |   | 13b. COUNTY<br>---  |  |   | 13c. CITY OR TOWN<br>BALTIMORE   |   |   |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>GEORGE W. TYLER   |   |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>DOROTHY SCHEPP                                 |  |   |  |   |   |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br>NO  |   |   | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br>212-26-1899                          |  |   | 17. INFORMANT<br>ADDRESS<br>VIRGINIA COLLINS 3 N. TREMONT ROAD, 21229  |   |   |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Respiratory &amp; Cardiovascular failure</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <u>Sepsis</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <u>Necrotizing Hemorrhagic Pancreatitis</u>       |   |   |   |  |   |  |   | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH<br><u>1 week</u><br><u>2 weeks</u><br><u>2 months</u>                         |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)   |   |   |   |  |   |  |   |   |
| 19a. DATE OF OPERATION<br><u>11/27/84</u>   |   |   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED<br><u>Necrotizing Hemorrhagic Pancreatitis</u> |  |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |   | 20b. IF YES, WERE FINDINGS USED<br>IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |   |   | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19                                      |  |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)   |   |   |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK  |   |   | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                          |  |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE  |   |   |
| 22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last<br>saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated<br>above, (I) (we) (did) (did not) view the body after death. |   |   |   |  |   |  |   |   |
| 22b. SIGNATURE<br><u>Dr. Michael Meyer</u>  |   |   | DEGREE<br>MD  |  |   | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> |   | 22c. DATE SIGNED<br><u>8/17/85</u>  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>DR. GEORGE MICHAEL MEYER   |   |   | 22e. ADDRESS<br>ST. AGNES HOSPITAL, 900 S. CATON AVENUE   |  |   |  |   |   |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br>BURIAL  |   |   | 23b. DATE<br>01-19-85   |  | 23c. NAME OF CEMETERY OR CREMATORY<br>LOUDON PARK |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>BALTIMORE CITY MARYLAND |   |
| 24. FUNERAL DIRECTOR<br>NAME<br>HUBBARD FUNERAL HOME, INC.  |   |   | ADDRESS<br>4107 WILKENS AVE.  |  |   | 25a. DATE REC'D. BY REGISTRAR<br>JAN 21 1985   |   | 25b. REGISTRAR'S SIGNATURE<br><u>Wilson-Randall</u>   |

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MEDICAL CERTIFICATION

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 4 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be returned by the hospital or attending physician.

OF FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 2 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked on item 18, show any injury, or other traumatic event, the medical examiner who viewed the body.

FOR  
STATE  
REGISTRAR

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|  |  |   |  |   |   |  |   |  |  |
|--|--|---|--|---|---|--|---|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br><b>ELIZABETH PARKER TYLER</b>   |  |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>1-22-85</b>  |   |   | 2b. HOUR<br><b>0745 M</b>  |   |  |  |
| 3. SEX<br><b>FEMALE</b>  |  | 4. RACE<br><b>WHITE</b>   |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>FEB 3 1918</b>   |   | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>66</b> YRS.  |   |  |  |
| 7b. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>MARYLAND</b>   |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>BALTIMORE CITY MD.</b>  |   |  |  |
| 10. CITY OR TOWN OF DEATH<br><b>BALTIMORE</b>  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>FRANCIS SCOTT KEY HOSP.</b> |  |   |   | 12a. USUAL OCCUPATION<br>(IF OF WORK FOR MOST OF WORKING LIFE)<br><b>SOCIAL WORKER</b>   |   | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>CO. GOV'T</b>  |  |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE<br><b>MARYLAND</b>  |  |   | 13b. COUNTY<br><b>A. A. C.</b>   |   | 13c. CITY OR TOWN<br><b>BUNNAPOLIS</b>                      |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>JOHN TYLER</b>  |  |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>ELIZABETH PARKER</b>                     |   |   |  |   |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>NO</b>  |  |   | 16b. SOCIAL SECURITY NO.<br><b>225 42 6869</b>   |   | 17. INFORMANT<br>ADDRESS<br><b>ELIZABETH P. TYLER #13</b>   |  |   |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>7 <b>8950</b> IMMEDIATE CAUSE (a) <b>Sepsis</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <b>53% Total Body Surface Area Burn</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <b>Stove Fire</b><br>Approximate Interval Between Onset and Death<br><b>3 weeks</b><br><b>6 weeks</b> |  |   |  |   |   |  |   |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a):<br><b>Renal Failure 2° Sepsis</b>  |  |   |  |   |   |  |   |  |  |
| 19a. DATE OF OPERATION<br><b>12/21/84</b>  |  |   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED<br><b>Remove Burned Skin and Skin Graft</b> |   |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>  |   | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  |   | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>11 30 1985</b>                         |   |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)<br><b>Kitchen Fire</b>                                      |   |  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> AT WORK NOT WHILE <input checked="" type="checkbox"/> AT WORK   |  |   | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)<br><b>Home</b>        |   |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE<br><b>3 South Gate Avenue Annapolis MD</b>   |   |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>1-3</b> , 19 <b>85</b> , to <b>1-22</b> , 19 <b>85</b> , that (I) (we) last saw the deceased alive on <b>1-22</b> , 19 <b>85</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.                            |  |   |  |   |   |  |   |  |  |
| 22b. SIGNATURE<br><b>Peter Loeb MD</b>   |  |   | DEGREE   |   |   | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> |   | 22c. DATE SIGNED<br><b>1-22-85</b>   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>PETER LOEB MD</b>  |  |   | 22e. ADDRESS<br><b>550 North Broadway, Apt 1105</b>  |   |   |  |   |  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>BURIAL</b>  |  |   | 23b. DATE<br><b>1-24-1985</b>  |   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Hillcrest Cem.</b> |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>ANAPOLIS A.A. MD</b>                           |  |  |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>TAYLOR FUNERAL CHAPEL</b>   |  |   | ADDRESS<br><b>ANAPOLIS MD.</b>   |   |   | 25a. DATE REC'D. BY REGISTRAR<br><b>JAN 23 1985</b>  |   | 25b. REGISTRAR'S SIGNATURE<br><b>[Signature]</b>   |  |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of page.

FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

85 01656

REG. NO.

|   |  |   |  |  |  |   |   |  |  |
|---|--|---|--|--|--|---|---|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br><b>VIRGIE TYLER</b>  |  |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>JANUARY 14, 1985</b> |  |  | 2b. HOUR<br>M<br><b>AM</b>  |   |  |  |
| 3. SEX<br><b>Female</b>   |  | 4. RACE<br><b>Black</b>   |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>10 17 17</b>  |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>67</b> YRS.                         |   | IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS.<br>HOURS MIN.   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Virginia</b>  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>      |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore City, MD.</b>        |   |  |  |
| 10. CITY OR TOWN OF DEATH<br><b>Baltimore</b>   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>1202 Maple Leaf Court</b> |  |  |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)          |   | 12b. KIND OF BUSINESS OR INDUSTRY  |  |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE<br><b>Maryland</b>   |  |   |  | 13b. COUNTY  |  | 13c. CITY OR TOWN<br><b>Baltimore</b>                                     |   | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                            |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Lewis Ball</b>   |  |   |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>- - -</b>  |  |   |   |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>NO</b>   |  | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br><b>219-03-5299</b>   |  | 17. INFORMANT<br>ADDRESS<br><b>Mary Reed 1202 Maple Leaf Court</b>   |  |   |   |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>UREMIA</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <b>chronic renal failure</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <b>7 years</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. |  |   |  |  |  |   |   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>7 years</b>   |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a):<br><b>-</b>  |  |   |  |  |  |   |   |  |  |
| 19a. DATE OF OPERATION<br><b>-</b>  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED<br><b>-</b>  |  |  |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |   | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>19</b>  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)  |  |   |   |  |  |
| 21d. INJURY OCCURRED<br>WHERE <input type="checkbox"/> NOT WHERE <input type="checkbox"/><br>AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE  |  |   |   |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) lost saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.   |  |   |  |  |  |   |   |  |  |
| 22b. SIGNATURE<br><b>Lucas Brown M.D.</b>   |  |   |  | DEGREE<br><b>M.D.</b> ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |  |   |   | 22c. DATE SIGNED<br><b>1-14-85</b>   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)   |  |   |  | 22e. ADDRESS   |  |   |   |  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br><b>BURIAL</b>  |  | 23b. DATE<br><b>1/19/85</b>   |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Arbutus Memorial Pk.</b>  |  |   | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Arbutus, MD.</b> |  |  |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>Wm C March F/H Inc.</b>  |  |   |  | ADDRESS<br><b>1101 E North Avenue</b>  |  | 25a. DATE REC'D. BY REGISTRAR<br><b>104 16 1985</b>                       |   | 25b. REGISTRAR'S SIGNATURE<br><b>Wm C March</b>  |  |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8501657

1- FOR  
STATE  
REGISTRAR

REG. NO.

|  |  |   |   |   |                                       |  |
|--|--|---|---|---|---------------------------------------|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br><b>ALBERT ULRICH</b>  |  |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>JANUARY 16 1985</b> |   | 2b. HOUR<br><b>10:22 P.M.</b>         |  |
| 3. SEX<br><b>Male</b>  |  | 4. RACE<br><b>White</b>   |   | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>8/6/1922</b>   |                                       |  |
| 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>62</b> YRS.  |  | 7. IF UNDER 1 YEAR<br>MONTHS DAYS<br><b>62</b>  |   | 8. IF UNDER 24 HRS.<br>HOURS MIN.<br><b>10:22</b>   |                                       |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Maryland</b>   |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>   |   | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |                                       |  |
| 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore City</b> MD.  |  | 10. CITY OR TOWN OF DEATH<br><b>Baltimore</b>   |   | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Church Hospital</b>                         |                                       |  |
| 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Laborer</b>   |  | 12b. KIND OF BUSINESS OR INDUSTRY   |   |   |                                       |  |
| 13a. STATE<br><b>Md.</b>   |  |   | 13b. COUNTY<br><b>---</b>                                     |   | 13c. CITY OR TOWN<br><b>Baltimore</b> |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST   |  |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST                 |   |                                       |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES AND OR UNKNOWN)<br><b>Yes</b>   |  | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br><b>W.W. 11 220-05-4830</b> |   | 17. INFORMANT<br>ADDRESS<br><b>Helen Ulrich 608 S. Clinton St.</b>  |                                       |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>RESPIRATORY ARREST</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <b>RESPIRATORY FAILURE</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <b>THROMBOCYTOPENIA</b>   |  |   |   |   |                                       |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <b>---</b>  |  |   |   |   |                                       |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                                      |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |                                       |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>19</b>                          |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |                                       |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |                                       |  |
| 22a. I certify that (I) (the <b>XX</b> hospital) attended the deceased from <b>DECEMBER 28, 1984</b> to <b>JANUARY 16, 1985</b> , that (I) (we) <b>X</b> saw the deceased alive on <b>JANUARY 16, 1985</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) <b>X</b> did not view the body after death. |  |   |   |   |                                       |  |
| 22b. SIGNATURE<br><b>L.K. Peredo</b>   |  | DEGREE<br><b>M.D.</b>   |   | 22c. DATE SIGNED<br><b>1/16/85</b>  |                                       |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>L. K. PEREDO M.D.</b>  |  | 22e. ADDRESS<br><b>CHURCH HOSPITAL<br/>100 NORTH BROADWAY 21213</b>                   |   |   |                                       |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>Burial</b>  |  | 23b. DATE<br><b>1/21/1985</b>   |   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Sacred Heart Cem.</b>  |                                       |  |
| 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Baltimore Md.</b>   |  | 23e. NAME OF CEMETERY OR CREMATORY  |   | 23f. LOCATION<br>CITY OR TOWN COUNTY STATE  |                                       |  |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>Lilly &amp; Zeiler Inc.</b>   |  | ADDRESS<br><b>1901 Eastern Ave.</b>   |   | 25a. DATE REC'D. BY REGISTRAR<br><b>JAN 22 1985</b>   |                                       |  |

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STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8501658

1- FOR  
STATE  
REGISTRAR

REG. NO.

|  |                                     |   |   |  |
|--|-------------------------------------|---|---|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>MILFORD Underwood R. Underwood<br>Underwood R. MILFORD  |                                     | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br>1- 2- 85   |   | 2b. HOUR<br>8:10 P.M.  |
| 3. SEX<br>m  | 4. RACE<br>B                        | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>3 7 03  |   | 6. AGE (IN YEARS LAST BIRTHDAY)<br>81 YRS.   |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>DEL   | 7b. CITIZEN OF WHAT COUNTRY?<br>USA | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |   |  |
| 9. BALTIMORE CITY OR COUNTY OF DEATH<br>BALTIMORE CITY MD.   |                                     | 10. CITY OR TOWN OF DEATH<br>Balto.   |   |  |
| 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>John Deaton Nursing Home  |                                     | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)  |   | 12b. KIND OF BUSINESS OR INDUSTRY  |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)  |                                     |   |   |  |
| 13a. STATE<br>Md.  | 13b. COUNTY                         | 13c. CITY OR TOWN<br>Balto.   | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | 13e. STREET ADDRESS / ZIP CODE<br>1611 S. Charles St. 21230                          |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>William Underwood  |                                     | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Ella Brittingham   |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)<br>No   |                                     | 16b. SOCIAL SECURITY NO.<br>104-12-7509   |   | 17. INFORMANT ADDRESS<br>Marguerite Dennis 11 W. 20th St.                            |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>pneumonia</u><br>DUE TO, OR AS A CONSEQUENCE OF (b) <u>operation of bronchial resection</u><br>DUE TO, OR AS A CONSEQUENCE OF (c) <u>weakness and malnutrition</u><br>CONDITIONS, IF ANY, WHICH GAVE RISE TO IMMEDIATE CAUSE (a), STATING THE UNDERLYING CAUSE LAST. |                                     |   |   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br>24 hrs<br>weeks<br>months            |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)<br><u>C.B.S.</u>   |                                     |   |   |  |
| 19a. DATE OF OPERATION   |                                     | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>   |                                     | 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)       |   |  |
| 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19   |                                     | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)  |   |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>   |                                     | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                    |
| 22a. I certify that (this hospital) attended the deceased from <u>1/2</u> 19 <u>84</u> , to <u>1/2</u> 19 <u>85</u> , that (my/we) last saw the deceased alive on <u>1/2</u> 19 <u>84</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (we) (did) (and we) view the body after death.   |                                     |   |   |  |
| 22b. SIGNATURE<br><u>Raymond Gladue, MD</u>  |                                     | DEGREE<br>ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>        |   | 22c. DATE SIGNED<br><u>1/3/85</u>  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)  |                                     | 22e. ADDRESS  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br>Burial   |                                     | 23b. DATE<br>1/7/85   |   | 23c. NAME OF CEMETERY OR CREMATORY<br>King Mem. Pk                                   |
| 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Balto. County  |                                     | 24. FUNERAL DIRECTOR<br>NAME ADDRESS<br>Wm. C. March F/H 1101 E. North Ave.   |   |  |
| 25a. DATE REC'D. BY REGISTRAR<br>JAN 4 1985  |                                     | 25b. REGISTRAR'S SIGNATURE<br><u>[Signature]</u>  |   |  |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 1 and 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.  
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.



STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 8501659

FOR  
1- STATE  
REGISTRAR

|   |                         |   |   |   |
|---|-------------------------|---|---|---|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br><b>Betty E. Valentine</b>                    |                         | 2a. DATE KNOWN OF DEATH<br>ESTD <input checked="" type="checkbox"/> MONTH DAY YEAR<br><b>1-9 1985</b>                                       |   | 2b. HOUR<br>M<br><b>6:53 a.m.</b>   |
| 3. SEX<br><b>Female</b>   | 4. RACE<br><b>White</b> | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>Oct 1 1951</b>   | 6. AGE (IN YEARS LAST BIRTHDAY)<br>YRS. MONTHS DAYS HOURS MIN<br><b>3 8 - -</b> | 7c. DATE PRONOUNCED DEAD<br>MONTH DAY YEAR<br><b>1-9 1985</b>   |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Md.</b>                             |                         | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>  |   | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |
| 10. CITY OR TOWN OF DEATH<br><b>Baltimore</b>                                       |                         | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Johns Hopkins Hospital</b> |   | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>NONE</b>  |
| 13a. STATE<br><b>Md.</b>  |                         | 13b. CITY OR TOWN<br><b>Balto.</b>  |   | 13c. STREET ADDRESS<br><b>21231 Regester Street</b>   |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Robert Valentine</b>                   |                         | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Shirley Sanders</b>   |   |   |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO, OR UNKNOWN)<br><b>No.</b> |                         | 16b. SOCIAL SECURITY NO.  |   | 17. INFORMANT<br>ADDRESS<br><b>Robert J. Valentine 218 S. Regester St.</b>  |

|  |  |  |
|--|--|--|
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Sudden Infant Death Syndrome</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____ |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
|--|--|--|

|   |   |   |
|---|---|---|
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).   |   |   |
| 19a. DATE OF OPERATION  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?           | 20. AUTOPSY?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |
| 21a. EXTERNAL CAUSE WAS<br>UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)       |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>   | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                   |
| 22a. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> . |   |   |
| ACTUAL SIGNATURE<br><i>Dennis F. Smyth</i> M.D. Assistant MEDICAL EXAMINER  |   | DATE SIGNED<br><b>1-10-85</b>   |
| EXAMINER'S NAME (TYPE OR PRINT) <b>Dennis F. Smyth, M.D.</b> ADDRESS <b>111 Penn St., Balto., Md. 21201</b>   |   |   |

|   |                             |   |  |
|---|-----------------------------|---|--|
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>Burial</b>                                      | 23b. DATE<br><b>1-11-85</b> | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Crestlawn Cemetery</b> | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Sykesville Howard Co. Md.</b> |
| 24. FUNERAL DIRECTOR<br>NAME ADDRESS<br><b>John M. Weber &amp; Sons Inc. 401 S. Chester St.</b> |                             | 25a. DATE REC'D. BY REGISTRAR<br><b>JAN 14 1985</b>             | 25b. REGISTRAR'S SIGNATURE<br><i>John Davidson</i>                             |

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL, TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

UNION

REPT MOTION & CO



WALKER

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 5 0 1 6 6 0

REG. NO.

1- FOR  
STATE  
REGISTRAR

|   |  |  |  |   |  |  |  |
|---|--|--|--|---|--|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>Elsie Valentine</b>                                      |  |  | 2a. DATE OF DEATH MONTH DAY YEAR<br><b>1-16-85</b> |   |  | 2b. HOUR<br><b>10<sup>30</sup> P.M.</b>  |  |
| 3. SEX<br><b>Female</b>   |  | 4. RACE<br><b>Black</b>  |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>2 5 1914</b>   |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>70</b> YRS.                                    |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Va.</b>   |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>  |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>City</b> MD.                              |  |
| 10. CITY OR TOWN OF DEATH<br><b>Balto.</b>  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Francis Scott Key Hospital</b> |  |   |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Housewife</b> |  |
| 12b. KIND OF BUSINESS OR INDUSTRY<br><b>Home</b>  |  | 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE<br><b>Md.</b>                       |  | 13b. CITY OR TOWN<br><b>Balto</b>   |  | 13c. CITY OR TOWN<br><b>Turners</b>  |  |
| 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 13e. STREET ADDRESS / ZIP CODE<br><b>118 Center St. 21222</b>  |  |   |  |  |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Silas G. Valentine</b>                             |  |  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Susie Hardy</b>   |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)                            |  | 16b. SOCIAL SECURITY NO.<br><b>213-14-3918A</b>  |  | 17. INFORMANT<br>ADDRESS<br><b>Margaret Valentine 118 Center St.</b>  |  |  |  |

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) **Cardiopulmonary Arrest**

DUE TO, OR AS A CONSEQUENCE OF

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last

(b) **Small Cell Carcinoma of lung**

DUE TO, OR AS A CONSEQUENCE OF

(c) **Acute Renal Failure**APPROXIMATE INTERVAL  
BETWEEN ONSET AND DEATH**15 min****Months****Days**

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)

MEDICAL CERTIFICATION

|   |  |  |  |   |  |  |  |
|---|--|--|--|---|--|--|--|
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                       |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>   |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>      |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)  |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |  |  |
| 22a. I certify that (I) (his hospital) attended the deceased from <b>1/16 1985</b> to <b>1/16 1985</b> , that (I) (we) lost <b>saw the deceased alive on</b> <b>1/16 1985</b> , and that in <b>(my)</b> (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. |  |  |  |   |  |  |  |
| 22b. SIGNATURE<br><b>Richard Bennett</b>  |  |  |  | DEGREE<br>ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |  | 22c. DATE SIGNED   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>Richard Bennett</b>   |  |  |  | 22e. ADDRESS  |  |  |  |

|   |  |                             |  |   |  |  |  |
|---|--|-----------------------------|--|---|--|--|--|
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>Burial</b>     |  | 23b. DATE<br><b>1-21-85</b> |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>MT. Calvary</b>    |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Balto Md.</b> |  |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>James A. MORTON &amp; SONS</b> |  |                             |  | ADDRESS<br><b>-1701 Laurens</b>                             |  | 25a. DATE REC'D. BY REGISTRAR<br><b>JAN 18 1985</b>            |  |
|   |  |                             |  | 25b. REGISTRAR'S SIGNATURE<br><b>Julia Davidson-Randall</b> |  |  |  |

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March

1901

Family

Vol.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

85 01661

|   |  |   |   |
|---|--|---|---|
| 1. FOR STATE REGISTRAR  |  | REG. NO.  |   |
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>FIRST MIDDLE LAST<br><b>MARIA VALENZIANO</b>   |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>1-5-1985</b><br>2b. HOUR<br><b>2:58 PM</b>  |   |
| 3. SEX<br><b>Female</b>   | 4. RACE<br><b>CAUCASIAN</b>  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>Dec 25, 1897</b>   |   |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Italy</b>   | 7b. CITIZEN OF WHAT COUNTRY?<br><b>Italy</b>   | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>87</b><br>YRS MONTHS DAYS<br>IF UNDER 1 YEAR<br>IF UNDER 24 HRS   | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |
| 10. CITY OR TOWN OF DEATH<br><b>BALTIMORE CITY</b>  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>St. Agnes Hospital</b> | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>BALTIMORE CITY</b>   |   |
| 12a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE<br><b>MD</b>   | 12b. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Homemaker</b>  | 12c. KIND OF BUSINESS OR INDUSTRY<br><b>Home</b>  |   |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Joseph VALENZIANO</b>  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>MARIA Di MARCO</b>   | 13b. CITY OR TOWN<br><b>BALTIMORE</b>   |   |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>No</b>   | 16b. SOCIAL SECURITY NO.<br><b>216-42-5439</b>   | 17. INFORMANT<br>ADDRESS<br><b>Mrs. Josephine Di Marco</b><br><b>5509 Forest Park Ave</b><br><b>BALTIMORE 21207</b>                             |   |
| 18. CAUSE OF DEATH (Enter only one cause per line for 1a, 1b, and 1c)<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Hypertensive Cardio-Vascular disease</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last<br>(b) <b>congestive heart failure</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <b>cardiac arrest</b> |  |   |   |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: 1a   |  |   |   |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |   |
| 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>   |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>                      |   |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |   |
| 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1b, PART 1 OR PART 2)  |  | 21d. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |   |
| 21e. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |   |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>9/8</b> , 19 <b>78</b> , to <b>1/5</b> , 19 <b>85</b> , that (I) (we) lost saw the deceased alive on <b>1/4/85</b> , 19 <b>85</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did not) view the body after death.  |  |   |   |
| 23a. SIGNATURE<br><b>JTB. LIBERTO</b>   |  | 23b. DEGREE<br><b>MD</b>  |   |
| 23c. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>JTB. LIBERTO, MD</b>  |  | 23d. ADDRESS<br><b>3508 BAYVIEW ST, BALTIMORE, MD 21224</b>   |   |
| 23e. DATE SIGNED<br><b>1/5/85</b>   |  | 23f. ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |   |
| 23g. BURIAL, CREMATION, REMOVAL<br><b>ENTOMBMENT</b>  |  | 23h. DATE<br><b>1-9-1985</b>  |   |
| 23i. NAME OF CEMETERY OR CREMATORY<br><b>Duhany Valley Maus.</b>  |  | 23j. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>BALTIMORE MD</b>   |   |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>Joseph N. ZANNINO JR.</b>  |  | 25a. DATE REC'D. BY REGISTRAR<br><b>JAN 8 1985</b>  |   |
| 25b. REGISTRAR'S SIGNATURE<br><b>Julia Davidson-Rendell</b>   |  | 25c. REGISTRAR'S SIGNATURE<br><b>Julia Davidson-Rendell</b>   |   |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page should be detached for use as the burial-transit permit. Then please remove carbon copies. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.  
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the attending physician must indicate the nature of the event.

MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH   |  |  |  |   |  |   |  |  |                      | 85 01662   |  |
|--|--|--|--|---|--|---|--|--|----------------------|--|--|
| 1. FOR STATE REGISTRAR   |  | REG. NO.   |  |   |  |   |  |  |                      |  |  |
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>FIRST MIDDLE LAST<br>RAMON VELEZ  |  |  |  |   |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br>JANUARY 10, 1985   |  |  | 2b. HOUR<br>11:09 PM |  |  |
| 3. SEX<br>Male   |  | 4. RACE<br>CAUC.   |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>March 6 1904  |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br>80 YRS.  |  | 7. UNDER 1 YEAR<br>MONTHS DAYS   |                      | IF UNDER 24 HRS<br>HOURS MIN.  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Puerto Rico   |  | 7b. CITIZEN OF WHAT COUNTRY?<br>USA  |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Baltimore City  |  |  | MD.                  |  |  |
| 10. CITY OR TOWN OF DEATH<br>Baltimore   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>Church Hospital |  |   |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Retired Merchant Seaman     |  | 12b. KIND OF BUSINESS OR INDUSTRY  |                      |  |  |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE COUNTY<br>Maryland Baltimore  |  |  |  | 13c. CITY OR TOWN<br>Dundalk  |  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  | 13e. STREET ADDRESS / ZIP CODE<br>566 S. 47th St. 21224  |                      |  |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>Domingo Velez  |  |  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Modesta Facio  |  |   |  |  |                      |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br>no   |  | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br>063-12-5235   |  | 17. INFORMANT<br>ADDRESS<br>Antonia Velez 566 S. 47th St. 21224   |  |   |  |  |                      |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>METASTATIC CARCINOMA</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>FROM CANCER OF CECUM AND CIRRHOSIS OF LIVER<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____   |  |  |  |   |  |   |  |  |                      | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH   |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)  |  |  |  |   |  |   |  |  |                      |  |  |
| <u>XX</u> JAUNDICE, ASCITES, PNEUMONIA   |  |  |  |   |  |   |  |  |                      |  |  |
| 19a. DATE OF OPERATION<br>1984<br>DECEMBER 24 1984   |  |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED<br>HEMICOLECTOMY   |  |   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |                      | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  |  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |  |   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)   |                      |  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK   |  |  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  |   |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE  |                      |  |  |
| 22a. I certify that (I) (the hospital) attended the deceased from <u>DECEMBER 21 1984</u> to <u>JANUARY 10 1985</u> , that <u>xx</u> (e) I saw the deceased alive on <u>JANUARY 10 1985</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. |  |  |  |   |  |   |  |  |                      |  |  |
| 22b. SIGNATURE<br><i>K. George Thomas</i>  |  |  |  | 22c. DATE SIGNED  |  |   |  | 22d. ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |                      |  |  |
| 22e. PHYSICIAN'S NAME (TYPE OR PRINT)<br>K. GEORGE THOMAS  |  |  |  | 22f. ADDRESS<br>100 NORTH BROADWAY 21213<br>CHURCH HOSPITAL   |  |   |  |  |                      |  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(TYPE OR PRINT)<br>Burial   |  |  |  | 23b. DATE<br>01-14-85   |  | 23c. NAME OF CEMETERY OR CREMATORY<br>Holly Hill Cem.   |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Baltimore, Md.   |                      |  |  |
| 24. FUNERAL DIRECTOR<br>Connelly Funeral Home of Dundalk   |  |  |  |   |  | 25a. DATE OF RECORD<br>JAN 16 1985  |  |  |                      |  |  |
| 25b. RECORDING SIGNATURE<br><i>John Davidson-Randall</i>   |  |  |  |   |  |   |  |  |                      |  |  |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 3 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical certificate must be filed with the medical examiner.

## MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH  |  |  |  | REG. NO. 8501663   |  |   |  |
|---|--|--|--|--|--|---|--|
| 1. FOR STATE REGISTRAR  |  |  |  | 7a. DATE OF DEATH MONTH DAY YEAR   |  |   |  |
| 1. DECEASED NAME (TYPE OR PRINT) <b>ARTHUR P. VENANZI</b>   |  |  |  | 7b. HOUR <b>7:08 AM</b>  |  |   |  |
| 3. SEX <b>MALE</b>  |  | 4. RACE <b>CAUCASIAN</b>   |  | 5. DATE OF BIRTH MONTH DAY YEAR <b>9-13-19</b>   |  | 6. AGE (IN YEARS LAST BIRTHDAY) <b>65</b> YRS   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Maryland</b>   |  | 7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>   |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH <b>BALTIMORE City MD.</b>  |  |
| 10. CITY OR TOWN OF DEATH <b>Baltimore</b>  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Sinai Hospital</b> |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Mgr. Canco MD.</b>  |  | 12b. KIND OF BUSINESS OR INDUSTRY <b>Credit Union</b>   |  |
| 13a. STATE <b>Maryland</b>  |  | 13b. COUNTY <b>Baltimore</b>   |  | 13c. CITY OR TOWN <b>Dundalk</b>   |  | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                            |  |
| 14. FATHER'S NAME FIRST MIDDLE LAST <b>Louis Venanzi</b>  |  | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Julia Carantonio</b>   |  | 13e. STREET ADDRESS <b>3557 McShane Way 21222</b>  |  |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>Yes</b>  |  | 16b. SOCIAL SECURITY NO. <b>WW II 215-01-2486</b>  |  | 17. INFORMANT ADDRESS <b>Dorothy M. Vananzi Same as 13e</b>  |  |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>electromechanical dissociation</b>  |  |  |  |  |  |   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>20 min</b> |
| DUE TO, OR AS A CONSEQUENCE OF, (b) <b>Worsening acidosis</b>   |  |  |  |  |  |   | <b>2 hrs</b>   |
| DUE TO, OR AS A CONSEQUENCE OF, (c) <b>Respiratory failure</b>  |  |  |  |  |  |   | <b>3 hrs</b>   |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <b>severe emphysema, COPD. (2) ventricular failure</b>   |  |  |  |  |  |   |  |
| 19a. DATE OF OPERATION <b>-</b>   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>-</b>  |  | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>   |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)   |  |   |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK  |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE   |  |   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>11/2/85</b> , 19 <b>85</b> , to <b>11/2/85</b> , 19 <b>85</b> , that (I) (we) lost saw the deceased alive on <b>11/2/85 6:30 pm</b> , 19 <b>85</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |  |  |  |  |  |   |  |
| 22b. SIGNATURE <b>Edward D. Zimmerman</b>   |  |  |  | DEGREE <b>ATTENDING PHYSICIAN</b> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>                          |  | 22c. DATE SIGNED <b>11/2/85</b>   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>Edward Zimmerman</b>   |  |  |  | 22e. ADDRESS <b>Sinai Hospital</b>   |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>   |  | 23b. DATE <b>1/5/1985</b>  |  | 23c. NAME OF CEMETERY OR CREMATORY <b>Oak Lawn</b>   |  | 23d. LOCATION CITY OR TOWN COUNTY STATE <b>Baltimore Maryland</b>   |  |
| 24. FUNERAL DIRECTOR <b>Duda-Ruck, Inc.</b> NAME ADDRESS <b>7922 Wise Avenue Dundalk, MD. 21222</b>   |  |  |  | 25a. DATE REC'D. BY REGISTRAR <b>JAN 7 1985</b> REGISTRAR'S SIGNATURE <b>John Davidson-Randall</b>   |  |   |  |

1401

U.S. DEPARTMENT OF AGRICULTURE  
BUREAU OF PLANT INDUSTRY

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STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

85 01664

REG. NO.

|  |  |  |  |   |  |
|--|--|--|--|---|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>FIRST MIDDLE LAST<br><b>RICHARD VENNEY</b>  |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>01/02/1985</b>   |  | 2b. HOUR<br><b>11:09 P.M.</b>   |  |
| 3. SEX<br><b>Male</b>  |  | 4. RACE<br><b>Black</b>  |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>1 - 30 - 1920</b>  |  |
| 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>64</b> YRS.  |  | IF UNDER 1 YEAR<br>MONTHS DAYS   |  | IF UNDER 24 HRS<br>HOURS MIN.   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Virginia</b>   |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A</b>   |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  |
| 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore City</b> MD.  |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Disability</b>  |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>Unknown</b>   |  |
| 10. CITY OR TOWN OF DEATH<br><b>Baltimore</b>  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>North Charles General Hospital</b> |  |   |  |
| 13a. STATE<br><b>Maryland</b>  |  | 13b. COUNTY<br><b>Baltimore</b>  |  | 13c. CITY OR TOWN<br><b>Baltimore</b>   |  |
| 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>  |  | 13e. STREET ADDRESS<br><b>520 N. Mt. Holly St.</b>   |  | 21229   |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Lloyd Veney</b>   |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Gertrude Wonson</b>  |  |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(IF YES, NO OR UNKNOWN)<br><b>Unknown</b>  |  | 16b. SOCIAL SECURITY NO.<br><b>139-18-5605</b>   |  | 17. INFORMANT<br>ADDRESS<br><b>Edna Veney 520 N. Mt. Holly St. 21229</b>  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>- RENAL FAILURE</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>MULTIPLE MYELOMA</b><br>DUE TO, OR AS A CONSEQUENCE OF (c) <b>CELLULITIS LEFT HAND - DAYS</b> |  |  |  |   |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a.  |  |  |  |   |  |
| 19a. DATE OF OPERATION<br><b>12/26/84</b>  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED<br><b>INND. OF ABSCESS HAND</b>   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  |
| 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  |  |  |   |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)<br>P.M. 19  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19   |  |   |  |
| 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)   |  |  |  |   |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NO! WORK AT WORK <input type="checkbox"/>   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |
| 22. I certify that (I) (this hospital) attended the deceased from <b>12/23/84</b> , 19 <b>84</b> , to <b>01/02/85</b> , 19 <b>85</b> , that (I) (we) last saw the deceased alive on <b>01/02/85</b> , 19 <b>85</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.                    |  |  |  |   |  |
| 22b. SIGNATURE<br><b>Amirah</b>  |  | DEGREE<br><b>MD</b>  |  | 22c. DATE SIGNED<br><b>1/2/85</b>   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>Amirah</b>   |  | 22e. ADDRESS<br><b>NORTH CHARLES HOSPITAL BALTIMORE, MD 21218</b>  |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>Burial</b>   |  | 23b. DATE<br><b>1-7-85</b>   |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Arbutus Memorial Park</b>  |  |
| 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Arbutus, Maryland</b>   |  |  |  |   |  |
| 24. FUNERAL DIRECTOR<br><b>The Bailey-Douglass Funeral Home</b>  |  | 25a. DATE REC'D. BY REGISTRAR<br><b>1 JAN 4 1985</b>   |  | 25b. REGISTRAR'S SIGNATURE<br><b>Juha Davidson-Randall</b>  |  |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use on the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.





REG. NO.

## MEDICAL CERTIFICATION

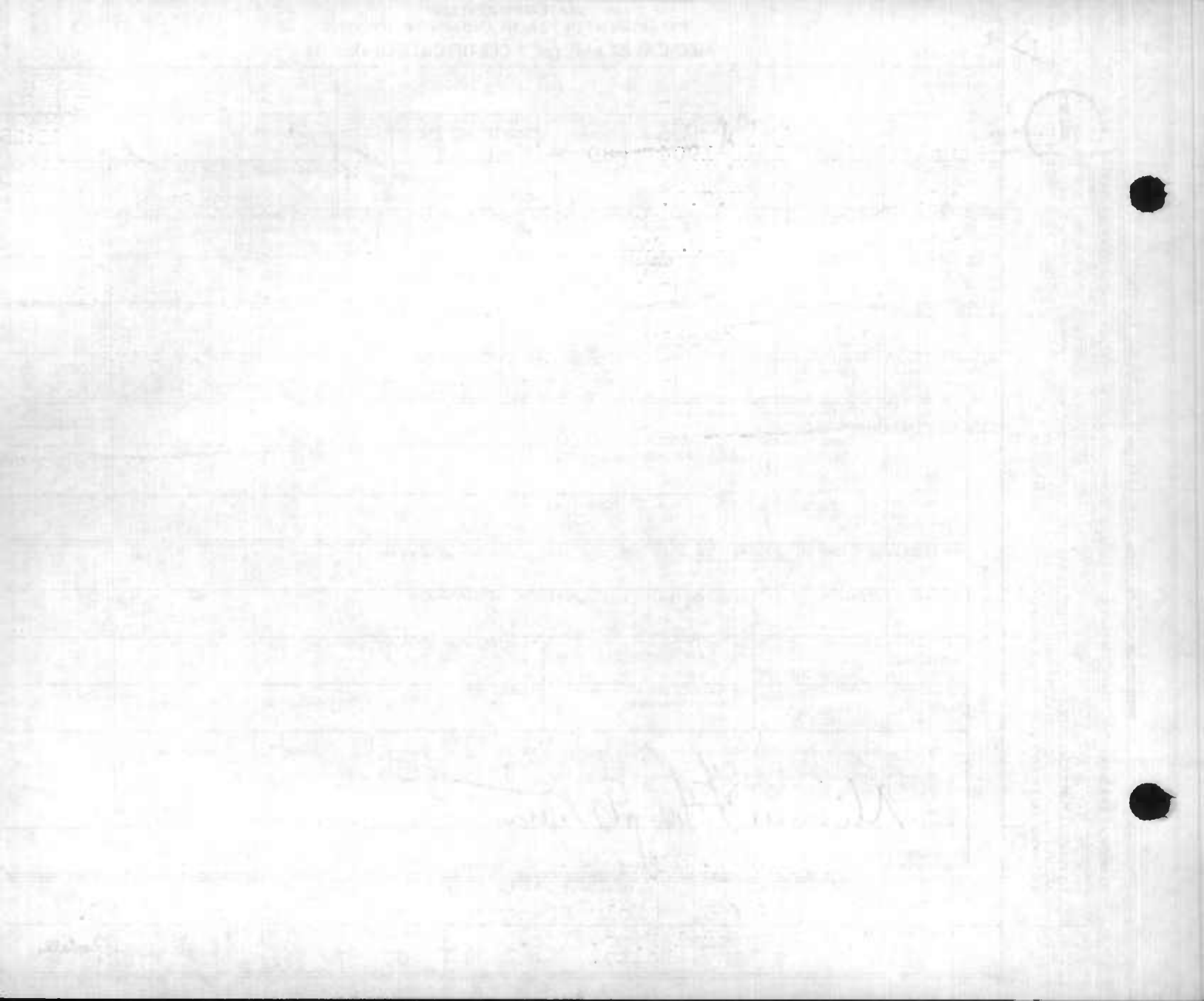
**TO MEDICAL EXAMINER:** THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 1B. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES.

**TO FUNERAL DIRECTOR:** PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP\_\_\_\_\_

DHMH - 17

(VR A15 ME (5))



UNION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

2 208 68 64

FOR STATE REGISTRAR  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH  
REG. NO.  
1. DECEASED NAME (TYPE OR PRINT) DUSTIN (NMN) WACHTER  
2a. DATE OF DEATH MONTH DAY YEAR 2b. HOUR 12:15 PM  
3. SEX MALE 4. RACE WHITE 5. DATE OF BIRTH MONTH DAY YEAR 12 3 1983 6. AGE (IN YEARS LAST BIRTHDAY) 1 YRS. 7. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland 7b. CITIZEN OF WHAT COUNTRY? U.S.A. 8. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐ 9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE CITY MD.  
10. CITY OR TOWN OF DEATH BALTIMORE 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) JOHNS HOPKINS HOSPITAL 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) 12b. KIND OF BUSINESS OR INDUSTRY  
13a. STATE Maryland 13b. COUNTY Frederick 13c. CITY OR TOWN Frederick 13d. INSIDE CITY LIMITS? YES ☒ NO ☐ 13e. STREET ADDRESS / ZIP CODE 1000 Heather Ridge Drive 21701  
14. FATHER'S NAME FIRST MIDDLE LAST Bruce Wachter 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Martina Maria Janetschka  
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No (IF YES, GIVE WAR OR DATES) 16b. SOCIAL SECURITY NO. None 17. INFORMANT ADDRESS 1000 Heather Ridge Drive Bruce Wachter, Frederick, MD. 21701  
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)  
PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Cardiorespiratory Arrest 3 1/2 hr  
(b) Cor pulmonale 1 yr  
(c) Bronchopulmonary Dysplasia 1 yr  
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)  
19a. DATE OF OPERATION N/A 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED N/A 20a. AUTOPSY? YES ☐ NO ☒ 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES ☐ NO ☐  
21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. N/A 19 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) N/A  
21d. INJURY OCCURRED 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) N/A 21f. LOCATION STREET CITY OR TOWN COUNTY STATE  
22a. I certify that (I) (this hospital) attended the deceased from Jan 16 19 85, to Jan 17 19 85, that (I) (we) last saw the deceased alive on Jan 17 19 85, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.  
22b. SIGNATURE B. McCrindle MD DEGREE 22c. DATE SIGNED 01/17/85  
22d. PHYSICIAN'S NAME (TYPE OR PRINT) B. McCrindle 22e. ADDRESS Johns Hopkins Hospital.  
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial 23b. DATE 1/19/85 23c. NAME OF CEMETERY OR CREMATORY Mt. Olivet Cmty 23d. LOCATION CITY OR TOWN COUNTY STATE Frederick, Frederick, MD.  
24. FUNERAL DIRECTOR NAME 1621 Opossumtown Pike G. Douglas Stauffer, Frederick, MD. 21701 25a. DATE REC'D. BY REGISTRAR JAN 25 1985 25b. REGISTRAR'S SIGNATURE

MEDICAL CERTIFICATION

1

10/10/77

5-508-77 P

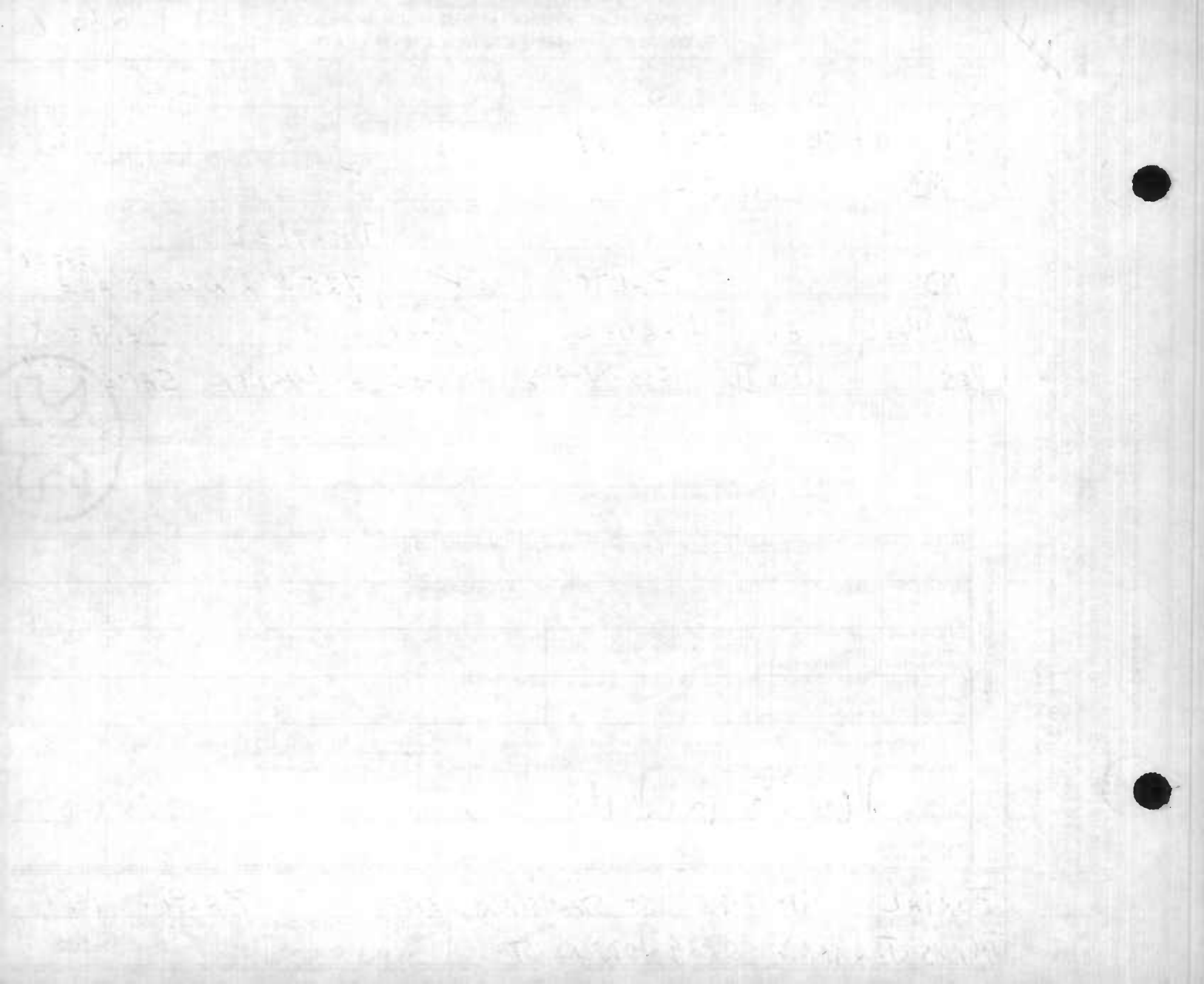


TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP \_\_\_\_\_  
DHMH - 17  
(VR A15 ME (5))

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>MEDICAL EXAMINER'S CERTIFICATE OF DEATH  |               |   |   |  |  |   |                                   |  |  | REG. NO. 5 0 1 6 6 7 |  |
|--|---------------|---|---|--|--|---|-----------------------------------|--|--|----------------------|--|
| 1- FOR STATE REGISTRAR<br>DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST<br>AUGUST S. WAGNER  |               |   |   |  |  | 2a. DATE KNOWN OF DEATH ESTI- MATED <input checked="" type="checkbox"/> MONTH DAY YEAR 1-14-85 19 |                                   | 2b. HOUR 4:30AM  |  |                      |  |
| 3. SEX M   | 4. RACE WHITE | 5. DATE OF BIRTH MONTH DAY YEAR 3-27-1915   | 6. AGE (IN YEARS LAST BIRTHDAY) 69 YRS. | 7. UNDER 24 YRS. MONTHS DAYS HOURS MIN   | 7c. DATE PRONOUNCED DEAD 1-14-85 19                                    |   | 7d. HOUR 4:30AM                   |  |  |                      |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN (CITY)) MD.   |               | 7b. CITIZEN OF WHAT COUNTRY? U.S.A.   |   | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD.   |                                   |  |  |                      |  |
| 10. CITY OR TOWN OF DEATH Baltimore  |               | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 725 S. Linwood Avenue |   |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) DISABLED |   | 12b. KIND OF BUSINESS OR INDUSTRY |  |  |                      |  |
| 13a. STATE MD.   |               | 13b. COUNTY BALTO.  |   | 13c. STREET ADDRESS 725 S. LINWOOD AVE   |  | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>      |                                   | 13e. CITY OR TOWN 21224  |  |                      |  |
| 14. FATHER'S NAME FIRST MIDDLE LAST MICHAEL A. WAGNER  |               |   |   | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST MARY DEMBECK  |  |   |                                   |  |  |                      |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) YES   |               |   |   | 16b. SOCIAL SECURITY NO. WW II 213-14-9186   |  | 17. INFORMANT ADDRESS MICHAEL A. WAGNER SAME 21224  |                                   |  |  |                      |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) Arteriosclerotic cardiovascular disease<br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____   |               |   |   |  |  |   |                                   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |                      |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 a.  |               |   |   |  |  |   |                                   |  |  |                      |  |
| 19a. DATE OF OPERATION   |               |   |   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?  |  |   |                                   | 20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |                      |  |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH  |               | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19  |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)  |  |   |                                   |  |  |                      |  |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>   |               | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)   |   | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE   |  |   |                                   |  |  |                      |  |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> . |               |   |   |  |  |   |                                   |  |  |                      |  |
| ACTUAL SIGNATURE Margaret A. Korrell   |               |   |   | TITLE (SPECIFY) M.D. Assistant MEDICAL EXAMINER  |  |   |                                   | DATE SIGNED 1-14-85  |  |                      |  |
| EXAMINER'S NAME (TYPE OR PRINT) Margarita A. Korrell, M.D.   |               |   |   | ADDRESS 111 Penn Street  |  |   |                                   |  |  |                      |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL   |               | 23b. DATE 1-17-85   |   | 23c. NAME OF CEMETERY OR CREMATORY ST. STANISLAUS CEM.   |  | 23d. LOCATION CITY OR TOWN COUNTY STATE BALTO. MD.  |                                   |  |  |                      |  |
| 24. FUNERAL DIRECTOR NAME THOMAS J. SKARDA ADDRESS 2529 HUDSON ST.   |               |   |   | 25a. DATE REC'D. BY REGISTRAR JAN 17 1985  |  | 25b. REGISTRAR'S SIGNATURE R. A. Korrell  |                                   |  |  |                      |  |

MEDICAL CERTIFICATION





STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8501668

1- FOR  
STATE  
REGISTRAR

REG. NO.

|  |  |   |  |   |  |   |  |   |  |
|--|--|---|--|---|--|---|--|---|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>Kevin Wald  |  |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br>January 2, 1985 |   |  | 2b. HOUR<br>12:15 P.M.  |  |   |  |
| 3. SEX<br>Female   |  | 4. RACE<br>White  |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>October 29, 1921  |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br>63 YRS.  |  | 7. IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS.<br>HOURS MIN. |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Kentucky  |  | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.A.  |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Baltimore City MD                                       |  |   |  |
| 10. CITY OR TOWN OF DEATH<br>Baltimore   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>South Baltimore Gen Hospital |  |   |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Homemaker                   |  | 12b. KIND OF BUSINESS OR INDUSTRY<br>Own Home                       |  |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)                    |  |   |  |   |  |   |  |   |  |
| 13a. STATE<br>Maryland   |  | 13b. COUNTY<br>Anne Arundel   |  | 13c. CITY OR TOWN<br>North Linthicum  |  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  | 13e. STREET ADDRESS / ZIP CODE<br>202 Regency Circle 21090          |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>Joseph Jackson   |  |   |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Mary Elizabeth Hammond   |  |   |  |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)<br>No N/A |  |   |  | 16b. SOCIAL SECURITY NO.<br>400-26-6311   |  | 17. INFORMANT (Son) 8229 Forest Glen Dr.<br>Mr. B. Craig Wald Pasadena, Md. 21122               |  |   |  |

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)  
PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a)

Cardiac dysrhythmia

APPROXIMATE INTERVAL  
BETWEEN ONSET AND DEATH

Immediate

DUE TO, OR AS A CONSEQUENCE OF

(b) Coronary heart disease

17 yrs.

DUE TO, OR AS A CONSEQUENCE OF

(c) Atherosclerotic CVD

Over 17 yrs.

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a):

MEDICAL CERTIFICATION

|   |  |  |  |  |  |   |  |
|---|--|--|--|--|--|---|--|
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                       |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>  |  | 20b. IF YES, WERE FINDINGS USED<br>IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19             |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)   |  |   |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE  |  |   |  |
| 22a. I certify that (I) (the deceased) attended the deceased from 8-23, 19 67, to 10-9, 19 84, that (we) last saw the deceased alive on 10-9, 19 84, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |  |  |  |  |  |   |  |
| 22b. SIGNATURE<br>Dr. Sidney Scherlis   |  |  |  | DEGREE<br>ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |  | 22c. DATE SIGNED<br>1-3-85  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>Dr. Sidney Scherlis  |  |  |  | 22e. ADDRESS<br>8415 Bellona Lane Ruxton Towers Suite 217<br>Towson, Maryland  |  |   |  |

|  |  |                           |  |  |  |  |  |
|--|--|---------------------------|--|--|--|--|--|
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br>Burial   |  | 23b. DATE<br>Jan. 5, 1985 |  | 23c. NAME OF CEMETERY OR CREMATORY<br>Meadowridge, Mem. Pk.                          |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Elkridge, Howard Md. |  |
| 24. FUNERAL DIRECTOR<br>NAME R. B. Hupkins ADDRESS<br>Singleton Funeral Home, Glen Burnie, Md. |  |                           |  | 25a. DATE RECEIVED BY REGISTRAR 25b. REGISTRAR'S SIGNATURE<br>JAN 8 1985 [Signature] |  |  |  |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

10

| Date |        | Description            |  | Amount  |  |
|------|--------|------------------------|--|---------|--|
| 1901 | Jan 1  | Balance                |  | 100.00  |  |
| 1901 | Jan 15 | Received from A. B. C. |  | 50.00   |  |
| 1901 | Feb 1  | Received from D. E. F. |  | 25.00   |  |
| 1901 | Mar 1  | Received from G. H. I. |  | 75.00   |  |
| 1901 | Apr 1  | Received from J. K. L. |  | 100.00  |  |
| 1901 | May 1  | Received from M. N. O. |  | 150.00  |  |
| 1901 | Jun 1  | Received from P. Q. R. |  | 200.00  |  |
| 1901 | Jul 1  | Received from S. T. U. |  | 250.00  |  |
| 1901 | Aug 1  | Received from V. W. X. |  | 300.00  |  |
| 1901 | Sep 1  | Received from Y. Z. A. |  | 350.00  |  |
| 1901 | Oct 1  | Received from B. C. D. |  | 400.00  |  |
| 1901 | Nov 1  | Received from E. F. G. |  | 450.00  |  |
| 1901 | Dec 1  | Received from H. I. J. |  | 500.00  |  |
| 1901 | Dec 31 | Total                  |  | 2500.00 |  |

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8501669

1- FOR  
STATE  
REGISTRAR

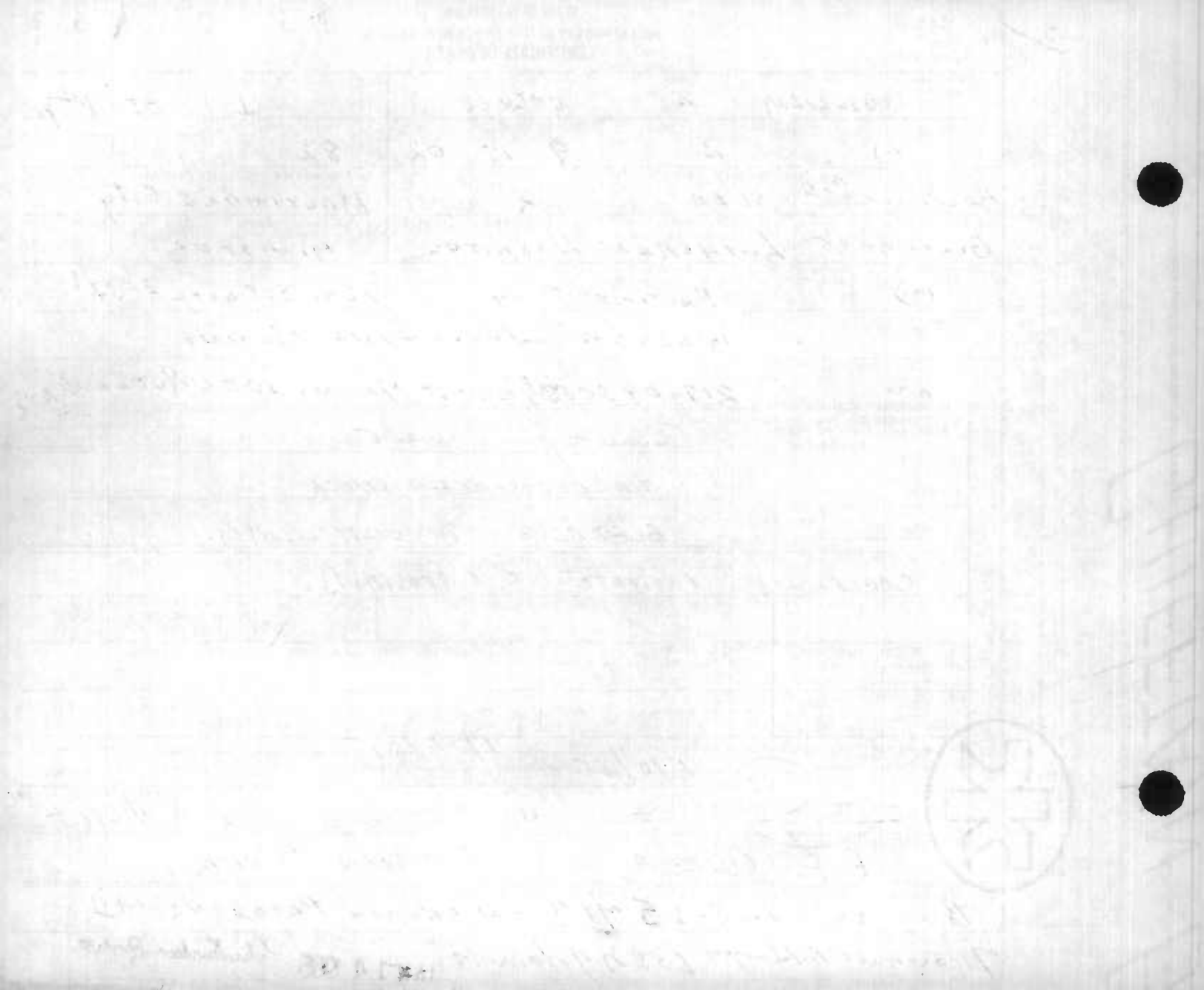
REG. NO.

|   |  |  |  |   |  |   |  |  |  |
|---|--|--|--|---|--|---|--|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>WILLIAM A. WALKER  |  |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br>1 10 85 |   |  | 2b. HOUR<br>1:42 PM   |  |  |  |
| 3. SEX<br>M   |  | 4. RACE<br>B   |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>9 17 02   |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br>82 YRS   |  | 7. IF UNDER 1 YEAR<br>MONTHS DAYS HOURS MIN.   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>BALTIMORE MD   |  | 7b. CITIZEN OF WHAT COUNTRY?<br>USA  |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>BALTIMORE CITY MD.                                      |  |  |  |
| 10. CITY OR TOWN OF DEATH<br>BALTIMORE  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>LUTHERAN HOSPITAL |  |   |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>MINISTER                    |  | 12b. KIND OF BUSINESS OR INDUSTRY  |  |
| 13a. STATE<br>MD  |  | 13b. COUNTY<br>BALTIMORE   |  | 13c. CITY OR TOWN<br>BALTIMORE  |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 13e. STREET ADDRESS / ZIP CODE<br>122 S. CASTLE ST 21231                             |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>WALKER  |  |  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>LORENNING MANN   |  |   |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br>NO  |  |  |  | 16b. SOCIAL SECURITY NO.<br>217-09-50585  |  | 17. INFORMANT<br>ADDRESS<br>FRANK MANN 1006 RUTLAND AVE   |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Cardiovascular arrest</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <u>IRREVERSIBLE SHOCK</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <u>BLEEDING DIVERTECULOSIS.</u> |  |  |  |   |  |   |  | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH                                      |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a<br><u>CARCINOMA PROSTATE C METASTASIS.</u>   |  |  |  |   |  |   |  |  |  |
| 19a. DATE OF OPERATION  |  |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  |   |  | 19c. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  |  |  | 20b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |  | 20c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)                  |  |  |  |
| 21a. INJURY OCCURRED<br>AT HOME <input type="checkbox"/> NOT AT HOME <input type="checkbox"/><br>AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>  |  |  |  | 21b. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21c. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from 1/10/85 to 1/10/85, that (I) (we) last saw the deceased alive on 1/10/85, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.     |  |  |  |   |  |   |  |  |  |
| 22b. SIGNATURE<br>P. E. CORREA MD.  |  |  |  | DEGREE<br>MD. ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>    |  |   |  | 22c. DATE SIGNED<br>1/10/85  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>P. E. CORREA   |  |  |  | 22e. ADDRESS<br>LUTHERAN HOSPITAL   |  |   |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>Burial   |  |  |  | 23b. DATE<br>1-15-85  |  | 23c. NAME OF CEMETERY OR CREMATORY<br>Mt Zion Church  |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>PARKERSBURG WV MD                      |  |
| 24. FUNERAL DIRECTOR<br>NAME<br>Marshall A. Hays (382) 911111   |  |  |  |   |  | 25a. DATE REC'D. BY REGISTRAR<br>JAN 14 1985  |  |  |  |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked on item 18 shows only injury, or other traumatic event, the medical examiner must be notified of same.



STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

85 01670

1- FOR  
STATE  
REGISTRAR

REG. NO.

|  |   |   |   |  |                                   |
|--|---|---|---|--|-----------------------------------|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>LEWIS WALLACE                 |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br>1 4 84   |   | 2b. HOUR<br>5:55 PM                              |                                   |
| 3. SEX<br>MALE   | 4. RACE<br>Black  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>8 24 00   |   | 6. AGE (IN YEARS LAST BIRTHDAY)<br>84 YRS.       |                                   |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>UNKNOWN                 | 7b. CITIZEN OF WHAT COUNTRY?<br>USA   | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>CITY MD. |                                   |
| 10. CITY OR TOWN OF DEATH<br>BART.                                   | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>LUTHERAN |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Retired                     |  | 12b. KIND OF BUSINESS OR INDUSTRY |
| 13a. STATE<br>BART   | 13b. COUNTY<br>BART   | 13c. CITY OR TOWN<br>BART   | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |                                   |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST                               |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST   |   |  |                                   |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) |   | 16b. SOCIAL SECURITY NO.  |   | 17. INFORMANT ADDRESS                            |                                   |

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)  
PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a)

MYOCARDIAL INFARCTION

DUE TO, OR AS A CONSEQUENCE OF

(b) Anterior wall Myocardial Infarction

DUE TO, OR AS A CONSEQUENCE OF

(c)

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)

MEDICAL CERTIFICATION

|   |  |  |   |
|---|--|--|---|
| 19a. DATE OF OPERATION  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                       | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER NOTIFY MEDICAL EXAMINER)   | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19             | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)       |   |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                    |   |
| 22a. I certify that (I) (this hospital) attended the deceased from<br>11/8/85 to 11/9/85, 19 85, that (I) (we) lost<br>saw the deceased alive on 11/8/85, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated<br>above, (I) (we) (did) (did not) view the body after death. |  |  |   |
| 22b. SIGNATURE<br>MARILYN DAVIS   |  | DEGREE<br>MD   | 22c. DATE SIGNED<br>11/6/85   |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)   |  | 22e. ADDRESS   |   |
| MARILYN DAVIS   |  | 9051 BART MARINE CT MD 21042   |   |

|  |                     |   |  |
|--|---------------------|---|--|
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br>Burial | 23b. DATE<br>1/8/85 | 23c. NAME OF CEMETERY OR CREMATORY<br>Druce Ridge | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Baltimore MD |
| 24. FUNERAL DIRECTOR<br>NAME<br>Murray M Wallace       |                     | 25a. DATE REC'D. BY REGISTRAR<br>JAN 11 1985      | 25b. REGISTRAR'S SIGNATURE<br>John F. Davis                |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

BP



POST OFFICE

CHILEAN W



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH  |  |  |  |  | REG. NO. 85 01671   |  |   |  |  |
|---|--|--|--|--|---|--|---|--|--|
| 1. DECEASED NAME (TYPE OR PRINT) <b>J. FIRST MAURICE WALLERSTEIN</b>  |  |  |  |  | 2a. DATE OF DEATH MONTH <b>1</b> DAY <b>12</b> YEAR <b>85</b> 2b. HOUR <b>3:45</b> P.M. |  |   |  |  |
| 3. SEX <b>Male</b>  |  | 4. RACE <b>WHITE</b>   |  | 5. DATE OF BIRTH MONTH <b>11</b> DAY <b>03</b> YEAR <b>94</b>  |   | 6. AGE (IN YEARS LAST BIRTHDAY) <b>90</b> YRS.   |   | IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.            |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>RUSSIA</b>   |  | 7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. BALTIMORE CITY OR COUNTY OF DEATH <b>Baltimore City</b> MD.                                 |   |  |  |
| 10. CITY OR TOWN OF DEATH <b>Baltimore</b>  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Sinai Hospital</b> |  |  |   | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>RETAIL</b>                    |   | 12b. KIND OF BUSINESS OR INDUSTRY <b>MERCHANT</b>                  |  |
| 13a. STATE <b>Maryland</b>  |  | 13b. COUNTY <b>Balt.</b>   |  | 13c. CITY OR TOWN <b>Balt.</b>   |   | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>   |   | 13e. STREET ADDRESS <b>APT. 216 (21210) 1190 W. Northern PKWay</b> |  |
| 14. FATHER'S NAME FIRST <b>GETZEL</b> MIDDLE LAST <b>WALLERSTEIN</b>  |  |  |  |  | 15. MOTHER'S MAIDEN NAME FIRST <b>SARAH</b> MIDDLE LAST <b>UNKNOWN</b>                  |  |   |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>NO</b>   |  | 16b. SOCIAL SECURITY NO. <b>219-07-5781</b>  |  | 17. INFORMANT ADDRESS <b>MRS. CAROL BLOOM 2310 SMITH AVE. 21209</b>  |   |  |   |  |  |
| 18. CAUSE OF DEATH: Enter only one cause per line for (a), (b), and (c):<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Cardio-resp. arrest</b><br>DUE TO, OR AS A CONSEQUENCE OF (b) <b>Cerebral vascular accident</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last }<br>DUE TO, OR AS A CONSEQUENCE OF (c) <b>Arteriosclerosis, D.M.</b><br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>minutes</b><br><b>2 days</b><br><b>Years</b> |  |  |  |  |   |  |   |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: 16.  |  |  |  |  |   |  |   |  |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  |  | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>                  |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> |  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)   |   |  |   |  |  |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE   |   |  |   |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>1/11</b> 19 <b>85</b> to <b>1/12</b> 19 <b>85</b> , that (I) (we) last saw the deceased alive on <b>1/12</b> 19 <b>85</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.  |  |  |  |  |   |  |   |  |  |
| 22b. SIGNATURE <b>Shari Sopher</b> DEGREE <b>9204</b>   |  |  |  | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>               |   |  | 22c. DATE SIGNED <b>1/12/85</b>   |  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>SHARI SOPHER</b>   |  |  |  | 22e. ADDRESS <b>SINAI HOSP.</b>  |   |  |   |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>BURIAL</b>   |  | 23b. DATE <b>1/13/85</b>   |  | 23c. NAME OF CEMETERY OR CREMATORY <b>ARLINGTON CEM</b>  |   | 23d. LOCATION CITY OR TOWN COUNTY STATE <b>BALTIMORE MARYLAND</b>                              |   |  |  |
| 24. FUNERAL DIRECTOR <b>SOL LEVINSON &amp; BROSING.</b> NAME ADDRESS  |  |  |  |  |   | 25a. DATE REC'D. BY REGISTRAR <b>JAN 17 1985</b> 25b. REGISTRAR'S SIGNATURE <b>na Davidson</b> |   |  |  |
| 6010 REISTERSTOWN RD. BALTIMORE, MARYLAND 21215   |  |  |  |  |   |  |   |  |  |

BP



2

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 5 0 1 6 7 2

FOR  
1- STATE  
REGISTRAR

REG. NO.

|   |  |   |  |  |   |
|---|--|---|--|--|---|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>Ella Walls   |  |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br>1-18-85                               |  | 2b. HOUR<br>M                             |
| 3. SEX<br>Female  | 4. RACE<br>Black   | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>1-15-1893   |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br>92 YRS.                   | IF UNDER 1 YEAR<br>MONTHS DAYS HOURS MIN. |
| 7a. BIRTHPLACE (STATE OR FOREIGN)<br>North Carolina   | 7b. CITIZEN OF WHAT COUNTRY?<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>U.S.A.                                       | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Baltimore, city MD.  |   |
| 10. CITY OR TOWN OF DEATH<br>Baltimore  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>Lutheran Hospital |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Domestic | 12b. KIND OF BUSINESS OR INDUSTRY<br>Unknown                 |   |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE<br>Maryland |  |   | 13b. COUNTY<br>City  | 13c. STREET ADDRESS<br>1633 N. Appleton St. 21217            |   |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>Unknown   |  |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Martha                      |  |   |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)<br>No            |  | 16b. SOCIAL SECURITY NO.<br>228-40-7861   |  | 17. INFORMANT<br>ADDRESS<br>Ozie Jacobs 1633 N. Appleton St. |   |

|  |  |   |
|--|--|---|
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) Myocardial Infarction |  | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH |
| DUE TO, OR AS A CONSEQUENCE OF<br>(b) generalized ASCVD  |  |   |
| DUE TO, OR AS A CONSEQUENCE OF<br>(c)  |  |   |

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a

MEDICAL CERTIFICATION

|   |  |  |   |
|---|--|--|---|
| 19a. DATE OF OPERATION  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                       | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 20b. IF YES, WERE FINDINGS USED<br>IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19             | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)       |   |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                    |   |
| 22a. I certify that (I) (this hospital) attended the deceased from 1981, 19 to JAN 1985, that (I) (we) lost saw the deceased alive on JAN 10 1985, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |  |  |   |
| 22b. SIGNATURE<br>Richard M. Hunt M.D.  |  | 22c. DATE SIGNED<br>1-22-85  |   |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>RICHARD M. HUNT, M.D.  |  | 22e. ADDRESS<br>800 BRADDOCK AVE   |   |

|   |                      |   |  |
|---|----------------------|---|--|
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br>Burial                  | 23b. DATE<br>1-23-85 | 23c. NAME OF CEMETERY OR CREMATORY<br>Mount Auburn Cemetery | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Baltimore Maryland |
| 24. FUNERAL DIRECTOR<br>NAME<br>Vernon R. Bailey 1348 N. Calhoun Street |                      | 25a. DATE REC'D. BY REGISTRAR<br>JAN 23 1985                |  |
|   |                      | 25b. REGISTRAR'S SIGNATURE<br>John R. Randall               |  |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.



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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

85 01673

1- FOR  
STATE  
REGISTRAR

REG. NO.

|  |  |   |  |  |                           |  |
|--|--|---|--|--|---------------------------|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>FIRST MIDDLE LAST<br><b>Agnes E. Walsh</b>  |  |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>January 25, 1985</b> |  | 2b. HOUR<br><b>10:48A</b> |  |
| 3. SEX<br><b>Female</b>  |  | 4. RACE<br><b>White</b>   |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>3- 4- 13</b>  |                           |  |
| 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>71</b> YRS.  |  | 7. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Balto. City</b> MD.  |  | 8. IF UNDER 1 YEAR<br>MONTHS DAYS HOURS MIN.<br>IF UNDER 24 HRS.   |                           |  |
| 9a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Md.</b>  |  | 9b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>   |  | 10. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |                           |  |
| 11. CITY OR TOWN OF DEATH<br><b>Balto.</b>   |  | 12. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Church Hospital</b> |  | 13. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Retired</b>   |                           |  |
| 14. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE<br><b>Md.</b>  |  | 13b. CITY OR TOWN<br><b>Balto.</b>  |  | 13c. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>  |                           |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Napoleon Laniewski</b>  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Tekla Marshall</b>  |  | 16. STREET ADDRESS / ZIP CODE<br><b>2513 Falt Ave. 21224</b>   |                           |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>No</b>  |  | 16b. SOCIAL SECURITY NO.<br><b>213-05-1145</b>  |  | 17. INFORMANT ADDRESS<br><b>John Walsh 5413 Cedella Ave. 21206</b>   |                           |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>MASSIVE INTRACEREBRAL BLEEDING</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last<br>(b) <b>HYPERTENSION</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) |  |   |  |  |                           |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)  |  |   |  |  |                           |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |                           |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)   |                           |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE  |                           |  |
| 22a. I certify that (I) (the hospital) attended the deceased from <b>January 15, 1985</b> to <b>January 25, 1985</b> , that (I) (we) last saw the deceased alive on <b>January 25, 1985</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did not) view the body after death.                             |  |   |  |  |                           |  |
| 22b. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>W. IMPAGLIATELLI, M.D.</b>   |  | 22c. ADDRESS<br><b>CHURCH HOSPITAL<br/>100 N. BROADWAY, BALTO., MD 21231</b>  |  | 22d. DATE SIGNED<br><b>1/25/85</b>   |                           |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>Burial</b>   |  | 23b. DATE<br><b>1-28-85</b>   |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>St. Stanislaus</b>  |                           |  |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>Schimunek Funeral Home, Inc. 21213</b>  |  | 24b. ADDRESS<br><b>3331 Brehms Lane</b>   |  | 25a. DATE REC'D. BY REGISTRAR<br><b>JAN 29 1985</b>  |                           |  |
| 25b. REGISTRAR'S SIGNATURE<br><b>Julia Davidson-Randall</b>  |  |   |  |  |                           |  |

BP



POST OFFICE  
NEW YORK, N.Y.

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8501674

FOR  
1 - STATE  
REGISTRAR

REG. NO.

|  |  |   |  |  |  |  |   |  |   |  |
|--|--|---|--|--|--|--|---|--|---|--|
| 1 DECEASED NAME<br>(TYPE OR PRINT)<br><b>Dorothy M Walsh</b>   |  |   | 2a DATE OF DEATH<br>MONTH DAY YEAR<br><b>January 26, 1985</b>          |  |  | 2b HOUR<br>M<br><b>M</b>   |   |  |   |  |
| 3 SEX<br><b>Female</b>   |  | 4 RACE<br><b>White</b>  |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>December 5, 1896</b>  |  | 6 AGE (IN YEARS LAST BIRTHDAY)<br><b>88</b>  |   | 7 UNDER 1 YEAR<br>MONTHS DAYS<br><b>YRS</b>  |   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Maryland</b>   |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>   |  | 8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9 BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore City</b> MD.   |   |  |   |  |
| 10. CITY OR TOWN OF DEATH<br><b>Baltimore</b>  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Garden Village Nursing Home</b> |  |  |  | 12a USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Housewife</b>  |   | 12b. KIND OF BUSINESS OR INDUSTRY  |   |  |
| 13a. STATE<br><b>Maryland</b>  |  |   | 13b. COUNTY  |  | 13c. CITY OR TOWN<br><b>Baltimore</b>  |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 13e. STREET ADDRESS / ZIP CODE<br><b>4626 Karon Ave 21206</b> |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>John L Gagliardi</b>  |  |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Adelaide ? ?</b>   |  |  |  |   |  |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) [IF YES, GIVE WAR OR DATES]<br><b>No</b>  |  |   | 16b. SOCIAL SECURITY NO.<br><b>213-05-0206</b>                         |  | 17. INFORMANT<br>ADDRESS<br><b>Joseph Fleischut Same As 13e</b>                |  |   |  |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>AS FND - AF CHF</b><br>DUE TO, OR AS A CONSEQUENCE OF (b) <b>Decubite ulcer left hip</b><br>DUE TO, OR AS A CONSEQUENCE OF (c)<br>CONDITIONS, if any, which gave rise to immediate cause (a), stating the underlying cause lost |  |   |  |  |  |  |   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH                  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)<br><b>Chemical Smog</b>   |  |   |  |  |  |  |   |  |   |  |
| 19a. DATE OF OPERATION   |  |   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                       |  |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |   | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |   |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  |   | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19             |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) |  |   |  |   |  |
| 21d. INJURY OCCURRED<br>WHERE <input type="checkbox"/> NOT WHERE <input type="checkbox"/><br>AT WORK AT WORK   |  |   | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                              |  |   |  |   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>1/25/85</b> to <b>1/26/85</b> , that (I) (we) lost saw the deceased alive on <b>1/25/85</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.                                       |  |   |  |  |  |  |   |  |   |  |
| 22b. SIGNATURE<br><b>Donald W. Mintzer M.D.</b>  |  |   | DEGREE<br><b>MD</b>  |  |  | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |   |  | 22c. DATE SIGNED<br><b>1/28/85</b>                            |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>Donald W Mintzer M.D.</b>  |  |   | 22e. ADDRESS<br><b>3009 Evergreen Ave Baltimore, Maryland</b>          |  |  |  |   |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>Burial</b>  |  |   | 23b. DATE<br><b>1/30/85</b>  |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Baltimore National</b>                |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Baltimore, Maryland</b>                        |  |   |  |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>Leonard J Ruck Inc. Baltimore, Maryland</b>   |  |   | ADDRESS  |  |  | 25a. DATE REC'D. BY REGISTRAR<br><b>JAN 29 1985</b>  |   | 25b. REGISTRAR'S SIGNATURE<br><b>Davidson-Randall</b>  |   |  |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 of 2 should be retained by the hospital or attending physician. Page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.  
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

100-44-3100



**STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH**

REG. NO.

1- FOR  
STATE  
REGISTRAR

|   |                         |   |  |   |  |   |  |  |  |   |  |
|---|-------------------------|---|--|---|--|---|--|--|--|---|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)   |                         | FIRST<br><b>ARMON</b>   |  | MIDDLE  |  | LAST<br><b>WALTON</b>   |  | 2a. DATE KNOWN OF DEATH<br>ESTIMATED <input checked="" type="checkbox"/> MONTH DAY YEAR<br>1-13-85 |  | 2b. HOUR<br>2:13P   |  |
| 3. SEX<br><b>Male</b>   | 4. RACE<br><b>White</b> | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>8 16 07</b>  |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>77 YRS.</b>   |  | IF UNDER 1 YR.<br>MONTHS DAYS   |  | IF UNDER 24 HRS.<br>HOURS MIN.   |  | 2c. DATE PRONOUNCED DEAD<br>MONTH DAY YEAR<br><b>1-13-85</b>                        |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Virginia</b>  |                         | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>   |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore City</b>                                     |  |  |  |   |  |
| 10. CITY OR TOWN OF DEATH<br><b>Baltimore</b>   |                         | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Key Medical Center</b> |  |   |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Welder-Rheems Manufactur.</b> |  | 12b. KIND OF BUSINESS OR INDUSTRY  |  |   |  |
| USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)  |                         |   |  |   |  |   |  |  |  |   |  |
| 13a. STATE<br><b>Maryland</b>   |                         | 13b. COUNTY<br><b>Baltimore</b>   |  | 13c. CITY OR TOWN<br><b>Edgemere</b>  |  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  | 13e. STREET ADDRESS<br><b>2817 Ross Avenue 21219</b>   |  |   |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>James Charles Walton</b>   |                         |   |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Rebecca Lutz</b>  |  |   |  |  |  |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO, OR UNKNOWN)<br><b>No</b>  |                         | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br><b>226-07-2305</b>   |  | 17. INFORMANT<br>ADDRESS<br><b>Dolly A. Walton Same as 13e</b>  |  |   |  |  |  |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Arteriosclerotic cardiovascular disease</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost.<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____  |                         |   |  |   |  |   |  |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH  |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)  |                         |   |  |   |  |   |  |  |  |   |  |
| 19a. DATE OF OPERATION  |                         |   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?   |  |   |  |  |  | 20. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH   |                         |   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)                     |  |  |  |   |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>  |                         |   |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)   |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |  |  |   |  |
| 22a. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: <b>Natural causes</b> <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> . |                         |   |  |   |  |   |  |  |  |   |  |
| ACTUAL SIGNATURE <b>Margaret A. Korell</b>  |                         |   |  |   |  | TITLE (SPECIFY)<br><b>M.D. Assistant</b>  |  | MEDICAL EXAMINER   |  | DATE SIGNED <b>1-14-85</b>  |  |
| EXAMINER'S NAME (TYPE OR PRINT) <b>Margarita A. Korell, M.D.</b>  |                         |   |  |   |  | ADDRESS <b>111 Penn Street</b>  |  |  |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>Burial</b>  |                         | 23b. DATE<br><b>1/16/85</b>   |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Oak Lawn</b>   |  |   |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Baltimore Maryland</b>                            |  |   |  |
| 24. FUNERAL DIRECTOR<br>NAME ADDRESS<br><b>Duda-Ruck, Inc. 7922 Wise Avenue Dundalk, MD. 21222</b>  |                         |   |  |   |  | 25a. DATE REC'D. BY REGISTRAR<br><b>JAN 18 1985</b>   |  | 25b. REGISTRAR'S SIGNATURE<br><i>[Signature]</i>   |  |   |  |

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. OBTAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

07/B4  
25M

BP  
DHMH - 17  
(VR A15 ME (5))

20% COTTON FIBER

DOWN

WINTER



MADE IN U.S.A.

MADE IN U.S.A.

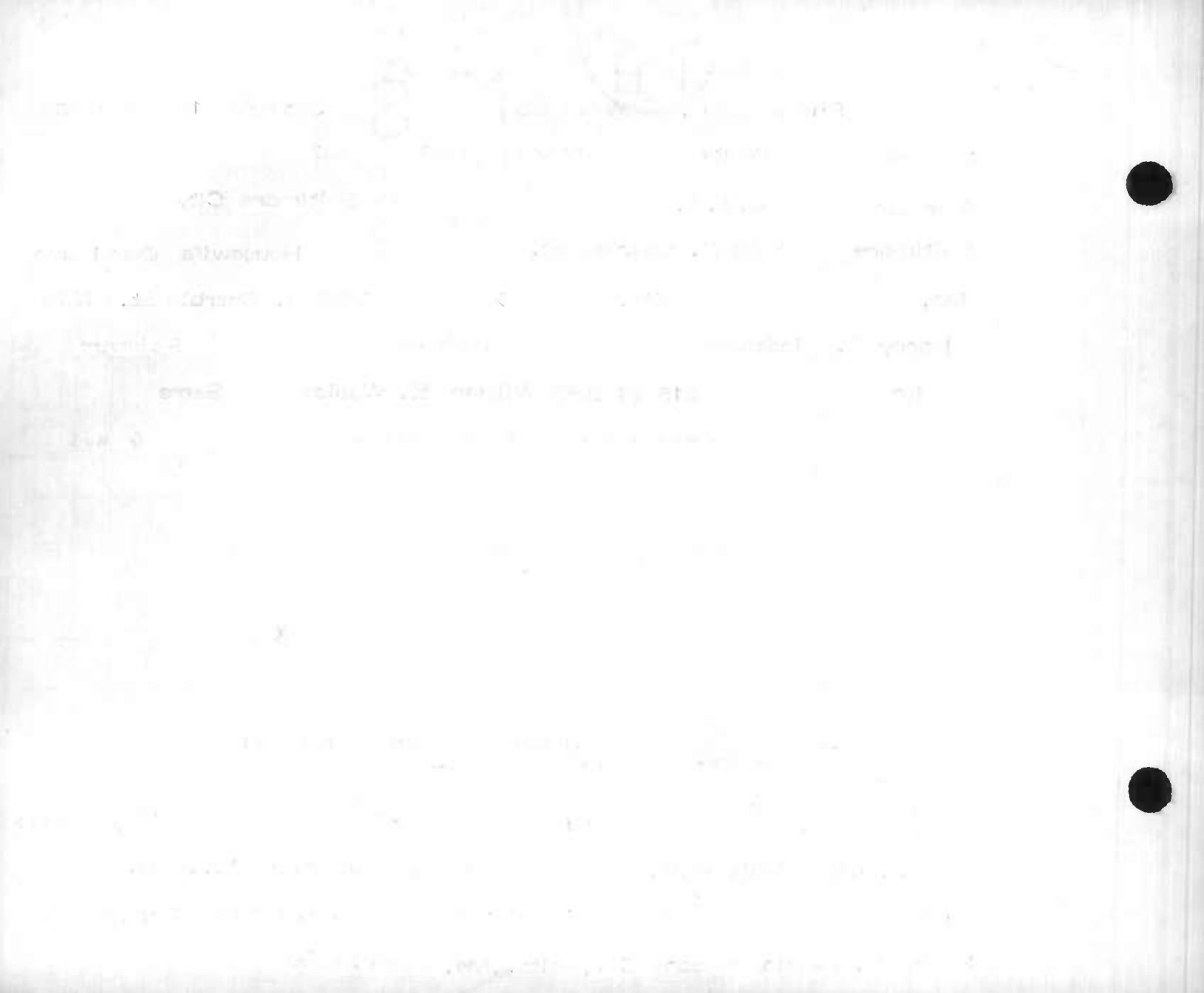
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

BP

DHMH - 16 50M 4/83  
(VRA 15, 4)TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.  
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH   |  |  |  |   | REG. NO.   |  |  |  |  |
|--|--|--|--|---|--|--|--|--|--|
| 1. FOR STATE REGISTRAR   |  |  |  |   |  |  |  |  |  |
| 2. DECEASED NAME<br>(TYPE OR PRINT)<br>FIRST MIDDLE LAST<br>Rhoda L. WAPLES  |  |  |  |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br>January 16 85 |  |  |  |  |
| 3. SEX<br>Female   |  | 4. RACE<br>White   |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>May 23 1897   |  | 6. AGE (IN YEARS, LAST BIRTHDAY)<br>87 YRS.  |  | 7b. HOUR<br>8:45p M  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Maryland  |  | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.A.   |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Baltimore City MD.   |  |  |  |
| 10. CITY OR TOWN OF DEATH<br>Baltimore   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>3900 N. Charles St. |  |   |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Housewife  |  | 12b. KIND OF BUSINESS OR INDUSTRY<br>Own Home  |  |
| 13a. STATE<br>Md.  |  | 13b. COUNTY<br>Balto.  |  | 13c. CITY OR TOWN<br>Balto.   |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>  |  | 13e. STREET ADDRESS / ZIP CODE<br>3900 N. Charles St. 21218  |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>Harry F. Lindeman  |  |  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Katharine Reichert   |  |  |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br>No   |  | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br>215 24 8267   |  | 17. INFORMANT<br>William E. Waples  |  | ADDRESS<br>Same  |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>CARCINOMA OF KIDNEY, METASTATIC</u>  |  |  |  |   |  |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br>6 mos  |  |
| DUE TO, OR AS A CONSEQUENCE OF<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____   |  |  |  |   |  |  |  |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: _____   |  |  |  |   |  |  |  |  |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  |   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |  |  |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |  |  |  |  |
| 22a. I certify that (I) <del>(the hospital)</del> attended the deceased from <u>11 JUNE</u> 19 <u>74</u> to <u>PRESENT</u> 19 <u>85</u> that (I) <del>have</del> last saw the deceased alive on <u>11 JAN</u> 19 <u>85</u> and that in (my) <del>own</del> opinion death occurred on the date and hour and from the causes stated above, (I) <del>must have</del> (did not) view the body after death. |  |  |  |   |  |  |  |  |  |
| 22b. SIGNATURE<br><u>J. Dixon Hills</u>  |  |  |  | DEGREE<br><u>MD</u>   |  | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |  | 22c. DATE SIGNED<br><u>17 July 1985</u>  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>J. Dixon Hills M.D.   |  |  |  | 22e. ADDRESS<br>3501 St. Paul St., Balto., Md.  |  |  |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br>Burial  |  | 23b. DATE<br>1-19-85   |  | 23c. NAME OF CEMETERY OR CREMATORY<br>Loudon Park   |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Baltimore Md.  |  |  |  |
| 24. FUNERAL DIRECTOR<br>NAME ADDRESS<br>Henry W. Jenkins & Sons Co., Balto., Md.   |  |  |  |   |  | 25a. DATE REC'D. BY REGISTRAR<br>JAN 18 1985   |  | 25b. REGISTRAR'S SIGNATURE<br><u>Davidson</u>  |  |



STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 5 0 1 6 7 7

FOR  
STATE  
REGISTRAR

REG. NO.

|  |  |   |   |  |  |
|--|--|---|---|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>Sister <i>Mary Juanita Ward</i> O.S.P.  |  |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><i>01 15 85</i>  |  | 2b. HOUR<br><i>6:15 AM</i>   |
| 3. SEX<br><i>Female</i>  | 4. RACE<br><i>Black</i>  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><i>10 16 19 65</i>  |   | 6. AGE (IN YEARS LAST BIRTHDAY)<br><i>65</i> YRS.                                    |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><i>Maryland</i>   | 7b. CITIZEN OF WHAT COUNTRY?<br><i>United States</i>   | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |   | BALTIMORE CITY OR COUNTY OF DEATH<br><i>Baltimore City</i> MD.                       |  |
| 10. CITY OR TOWN OF DEATH<br><i>Baltimore</i>  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><i>South Baltimore General Hospital</i> |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><i>Min-school principal</i> |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><i>Convent</i>  |
| 13a. STATE<br><i>Maryland</i>  | 13b. COUNTY<br><i>Baltimore</i>  | 13c. CITY OR TOWN<br><i>Baltimore</i>   | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | 13e. STREET ADDRESS / ZIP CODE<br><i>3333 Windsor Ave, Baltimore md 21216</i>        |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><i>Eli Ward</i>  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><i>Martha Washington</i>   |   |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)<br><i>NO</i>  |  | 16b. SOCIAL SECURITY NO.<br><i>220607867</i>  |   | 17. INFORMANT<br>ADDRESS<br><i>Sister Mary Paul Lee 701 Gun Road</i>                 |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <i>Cardiopulmonary Arrest</i><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <i>Cholangio Carcinoma</i><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c)   |  |   |   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><i>5 minutes</i>   |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 11a.   |  |   |   |  |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)       |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                    |  |
| 22a. I certify that (1) (this hospital) attended the deceased from <i>January 02, 19 85</i> to <i>January 15, 19 85</i> , that (1) (we) last saw the deceased on <i>January 15, 19 85</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (1) (we) (did) (did not) view the body after death. |  |   |   |  |  |
| 22b. SIGNATURE<br><i>Malinda H. White</i>  |  | DEGREE<br><i>MD</i>   |   | 22c. DATE SIGNED<br><i>1-15-85</i>   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><i>Malinda H. White</i>   |  | 22e. ADDRESS<br><i>South Baltimore General Hospital, Baltimore md</i>   |   |  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br><i>BURIAL</i>   |  | 23b. DATE<br><i>1/19/85</i>   |   | 23c. NAME OF CEMETERY OR CREMATORY<br><i>New Cathedral Cem.</i>                      |  |
|  |  |   |   | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><i>Baltimore, Md.</i>                  |  |
| 24. FUNERAL DIRECTOR<br>NAME<br><i>Wm C March F/H Inc. 1101 E North Avenue</i>   |  |   | 25a. DATE REC'D. BY REGISTRAR<br><i>JAN 17 1985</i>   |  |  |
|  |  |   | 25b. REGISTRAR'S SIGNATURE<br><i>John Davidson-Randall</i>                                      |  |  |

35  
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300

MEDICAL CERTIFICATION

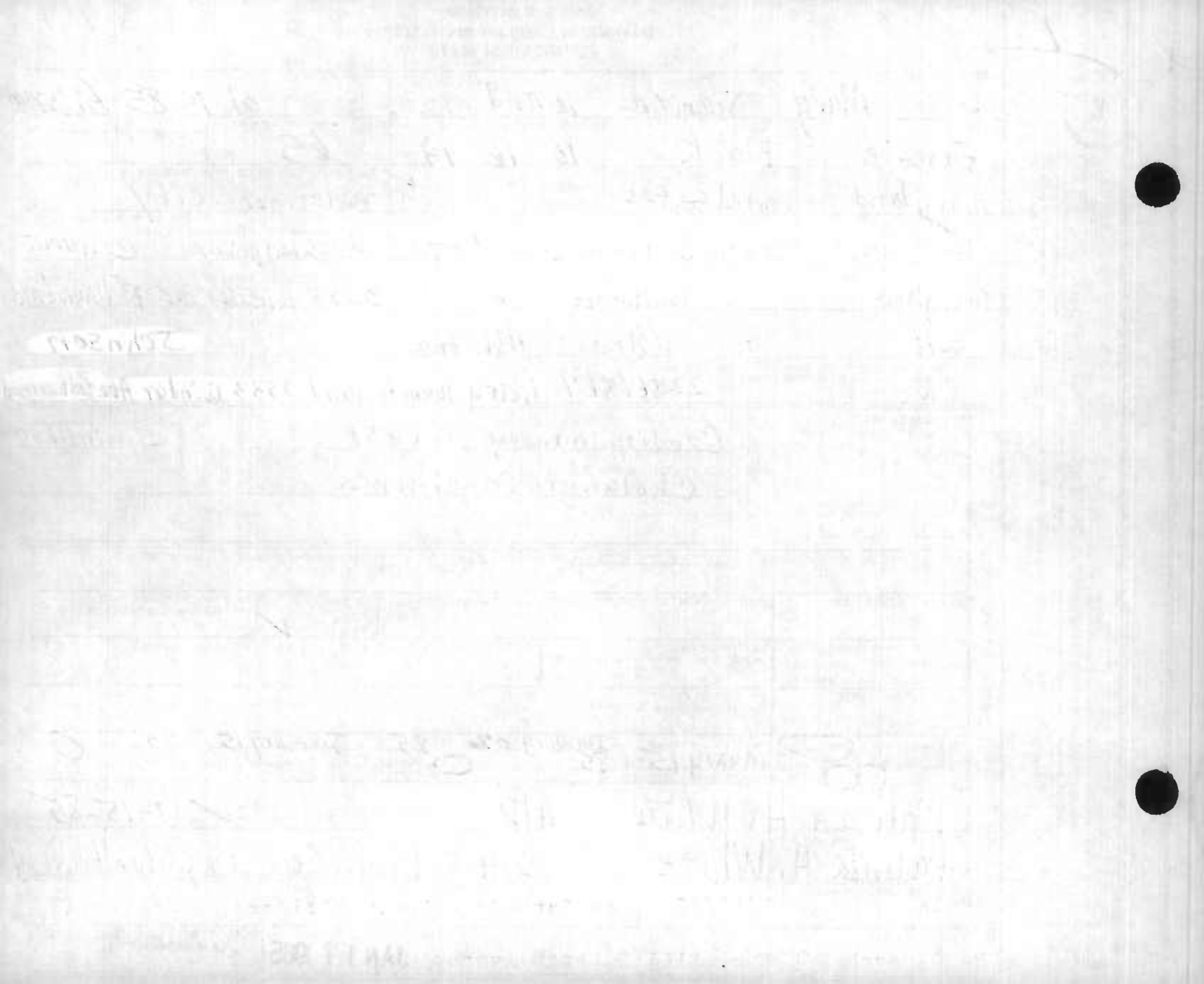
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9

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of once.



STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 5 0 1 6 7 8

1. FOR  
STATE  
REGISTRAR

REG. NO.

|   |  |   |  |   |  |
|---|--|---|--|---|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>FIRST MIDDLE LAST<br><b>Rosalie Washington</b>   |  |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>January 21, 1985</b>                             |   | 2b. HOUR<br>M<br><b>AM</b>   |
| 3. SEX<br><b>Female</b>   | 4. RACE<br><b>Black</b>  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>10 16 18</b>   |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>66</b> YRS.   | IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS.<br>HOURS MIN.   |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>MD</b>  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>   | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore City, MD.</b>                              |  |
| 10. CITY OR TOWN OF DEATH<br><b>Baltimore</b>   | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>4021 Old York Road</b> |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)                           | 12b. KIND OF BUSINESS OR INDUSTRY   |  |
| 13a. STATE<br><b>Maryland</b>   |  | 13b. COUNTY   | 13c. CITY OR TOWN<br><b>Baltimore</b>  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Daniel Chaney</b>  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Sadie Briscoe</b>   |  | 13e. STREET ADDRESS / ZIP CODE<br><b>4021 Old York Rd. 21218</b>                                |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)<br><b>No</b>   |  | 16b. SOCIAL SECURITY NO.<br><b>219-22-0774</b>  |  | 17. INFORMANT<br>ADDRESS<br><b>Paul Haley 4021 Old York Rd.</b>                                 |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Aspiration pneumonia</b><br>DUE TO, OR AS A CONSEQUENCE OF (b) <b>Tracheo-esophageal fistula</b><br>DUE TO, OR AS A CONSEQUENCE OF (c) <b>Esophageal cancer</b>   |  |   |  |   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>1-2 days</b><br><b>1 week</b><br><b>1-2 years</b>                       |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <b>—</b>   |  |   |  |   |  |
| 19a. DATE OF OPERATION<br><b>—</b>  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED<br><b>—</b>  |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>            | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>—</b>   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)<br><b>—</b> |   |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)<br><b>—</b>  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE<br><b>— Baltimore MD</b>                 |   |  |
| 22a. I certify that (this hospital) attended the deceased from <b>Jan 5, 1985</b> to <b>Jan 17, 1985</b> , that (I) <del>was</del> lost<br>saw the deceased alive on <b>Jan 17, 1985</b> , and that in (my) <del>own</del> opinion death occurred on the date and hour and from the causes stated<br>above, (I) <del>did not</del> (did not) view the body after death. |  |   |  |   |  |
| 22b. SIGNATURE<br><b>Susan McKeonans MD</b>   |  | DEGREE<br><b>MD</b>   |  | 22c. DATE SIGNED<br><b>1/22/85</b>  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>SUSAN M. McKEONANS, MD</b>  |  | 22e. ADDRESS<br><b>UNION MEMORIAL HOSP<br/>201 E. UNIV. PKWY BALTO., MD 21218</b>   |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>Burial</b>   | 23b. DATE<br><b>1/26/85</b>  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Mt. Zion Cemetery</b>  |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Baltimore MD</b>                               |  |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>Wm C March F/H Inc.</b>  |  | ADDRESS<br><b>1101 E North Avenue</b>   |  | 25a. DATE REC'D. BY REGISTRAR<br><b>JAN 23 1985</b>   |  |
|   |  |   |  | 25b. REGISTRAR'S SIGNATURE<br><b>Davidson-Randall</b>   |  |

BP

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 1 and 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP  
DHMH - 16 50M 4/83  
(VRA 15, 4)

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH  |  |         |  |   |                                    |  |   |  |                                      | REG. NO.   |                              |  |
|---|--|---------|--|---|------------------------------------|--|---|--|--------------------------------------|--|------------------------------|--|
| 1. FOR STATE REGISTRAR  |  |         | 1. DECEASED NAME (TYPE OR PRINT)   |   |                                    | 2a. DATE OF DEATH  |   |  | 2b. HOUR                             |  |                              |  |
|   |  |         | CAROLINE S. WATERS   |   |                                    | 1 30 85  |   |  | 6 P.M.                               |  |                              |  |
| 3. SEX  |  | 4. RACE |  | 5. DATE OF BIRTH  |                                    | 6. AGE (IN YEARS LAST BIRTHDAY)  |   | 7. UNDER 1 YEAR  |                                      | 7. UNDER 24 HRS.   |                              |  |
| Female  |  | White   |  | 9 1 92  |                                    | 92 YRS   |   | MONTHS   |                                      | DAYS   |                              |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)   |  |         | 7b. CITIZEN OF WHAT COUNTRY?   |   |                                    | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |   |  | 9. BALTIMORE CITY OR COUNTY OF DEATH |  |                              |  |
| PA.   |  |         | USA  |   |                                    |  |   |  | BALTIMORE CITY MD                    |  |                              |  |
| 10. CITY OR TOWN OF DEATH   |  |         | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) |   |                                    | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)  |   |  | 12b. KIND OF BUSINESS OR INDUSTRY    |  |                              |  |
| BALTIMORE   |  |         | Church Home CORP.  |   |                                    | Homemaker  |   |  | Own Home                             |  |                              |  |
| 13a. STATE  |  |         | 13b. COUNTY  |   | 13c. CITY OR TOWN                  |  | 13d. INSIDE CITY LIMITS?  |  | 13e. STREET ADDRESS / ZIP CODE       |  |                              |  |
| Md.   |  |         |  |   | BALTIMORE                          |  | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 101 N. Bond ST. 21231                |  |                              |  |
| 14. FATHER'S NAME   |  |         |  |   | 15. MOTHER'S MAIDEN NAME           |  |   |  |                                      |  |                              |  |
| Harvey Shoemaker  |  |         |  |   | Laura M. Lane                      |  |   |  |                                      |  |                              |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)   |  |         |  |   | 16b. SOCIAL SECURITY NO.           |  | 17. INFORMANT ADDRESS   |  |                                      |  |                              |  |
| No  |  |         |  |   | 219-30-6981                        |  | Mrs. Krysiak, Balto., MD  |  |                                      |  |                              |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)   |  |         |  |   |                                    |  |   |  |                                      | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH                   |                              |  |
| PART I. DEATH WAS CAUSED BY   |  |         |  |   |                                    |  |   |  |                                      |  |                              |  |
| IMMEDIATE CAUSE (a) <u>RESPIRATORY ARREST</u>   |  |         |  |   |                                    |  |   |  |                                      |  |                              |  |
| DUE TO, OR AS A CONSEQUENCE OF  |  |         |  |   |                                    |  |   |  |                                      |  |                              |  |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.  |  |         |  |   |                                    |  |   |  |                                      |  |                              |  |
| (b) <u>ARTHERIO SCLEROTIC CARDIO VASCULAR disease</u>   |  |         |  |   |                                    |  |   |  |                                      |  |                              |  |
| DUE TO, OR AS A CONSEQUENCE OF  |  |         |  |   |                                    |  |   |  |                                      |  |                              |  |
| (c) <u>PERIPHERAL VASCULAR disease</u>  |  |         |  |   |                                    |  |   |  |                                      |  |                              |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: 11a  |  |         |  |   |                                    |  |   |  |                                      |  |                              |  |
| 19a. DATE OF OPERATION  |  |         |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                    |                                    |  |   | 20a. AUTOPSY?  |                                      | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? |                              |  |
|   |  |         |  |   |                                    |  |   | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>            |                                      | YES <input type="checkbox"/> NO <input type="checkbox"/>       |                              |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |  |         |  | 21b. TIME OF INJURY   |                                    |  |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) |                                      |  |                              |  |
|   |  |         |  | HOUR A.M. MONTH DAY YEAR  |                                    |  |   |  |                                      |  |                              |  |
|   |  |         |  | P.M. 19   |                                    |  |   |  |                                      |  |                              |  |
| 21d. INJURY OCCURRED  |  |         |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) |                                    |  |   | 21f. LOCATION  |                                      |  |                              |  |
| WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>   |  |         |  |   |                                    |  |   | STREET CITY OR TOWN COUNTY STATE   |                                      |  |                              |  |
| 22a. I certify that (1) this hospital attended the deceased from 19 77 to 1-30 19 85, that (1) (we) last saw the deceased alive on 1-30 19 85, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (1) (we) (did) (did not) view the body after death. |  |         |  |   |                                    |  |   |  |                                      |  |                              |  |
| 22b. SIGNATURE  |  |         |  | DEGREE  |                                    |  |   | 22c. DATE SIGNED   |                                      |  |                              |  |
| L.K. Peredo   |  |         |  | M.D.  |                                    |  |   | 1/30/85  |                                      |  |                              |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)   |  |         |  | 22e. ADDRESS  |                                    |  |   |  |                                      |  |                              |  |
| L.K. Peredo, MD.  |  |         |  | Church Hospital, Balto., MD   |                                    |  |   |  |                                      |  |                              |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)   |  |         | 23b. DATE  |   | 23c. NAME OF CEMETERY OR CREMATORY |  |   | 23d. LOCATION  |                                      |  | 23e. DATE REC'D BY REGISTRAR |  |
| Cremation   |  |         | 2/2/85   |   | Green Mount                        |  |   | Balto., MD   |                                      |  | FEB 4 - 1985                 |  |
| 24. FUNERAL DIRECTOR  |  |         |  |   | 25a. DATE REC'D BY REGISTRAR       |  |   |  |                                      | 25b. REGISTRAR'S SIGNATURE                                     |                              |  |
| NAME Henry W. Jenkins & Sons Co.  |  |         |  |   | FEB 4 - 1985                       |  |   |  |                                      | Gina Jones   |                              |  |
| 4905 York Road Balto., MD 21212   |  |         |  |   |                                    |  |   |  |                                      |  |                              |  |

MEDICAL CERTIFICATION

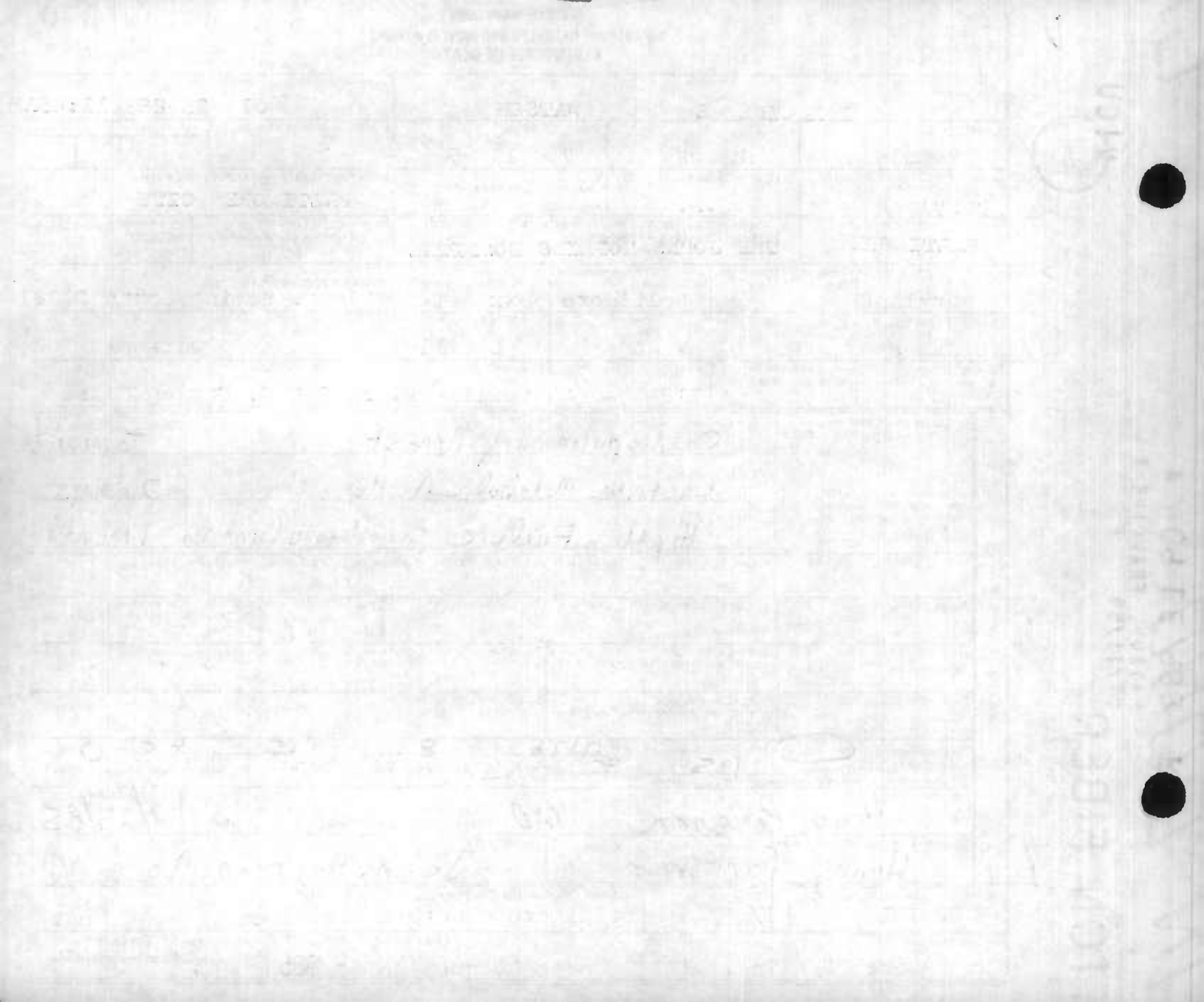


1 DIVISION OF VITAL RECORDS, 600 N. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: This certificate should be retained by the hospital or attending physician and completely filled in by the funeral director within 72 hours after death. If the deceased was under 18 years of age, the certificate should be filled in by the funeral director within 72 hours after death. If the deceased was 18 years of age or older, the certificate should be filled in by the funeral director within 72 hours after death. If the deceased was 18 years of age or older, the certificate should be filled in by the funeral director within 72 hours after death. If the deceased was 18 years of age or older, the certificate should be filled in by the funeral director within 72 hours after death.

DHMH - 16 50M 4/83  
(VRA 15, 4)

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH   |  |  |  |   |  | 8 5 0 1 6 8 0  |  |   |  |
|--|--|--|--|---|--|--|--|---|--|
| 1. FOR STATE REGISTRAR   |  |  |  |   |  | REG. NO.   |  |   |  |
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br><b>FRANCINE E WATSON</b>  |  |  |  |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>01 25 85</b> |  |  | 2b. HOUR<br><b>11:45AM</b>  |  |
| 3. SEX<br><b>Female</b>  |  | 4. RACE<br><b>black</b>  |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>7 11 59</b>  |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>25</b> YRS   |  | IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS<br>HOURS MIN.                                     |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Maryland</b>   |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>  |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>BALTIMORE CITY MD</b>   |  |   |  |
| 10. CITY OR TOWN OF DEATH<br><b>BALTIMORE</b>  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>THE JOHNS HOPKINS HOSPITAL</b> |  |   |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)   |  | 12b. KIND OF BUSINESS OR INDUSTRY   |  |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)  |  |  |  |   |  |  |  |   |  |
| 13a. STATE<br><b>Maryland</b>  |  | 13b. COUNTY  |  | 13c. CITY OR TOWN<br><b>Baltimore</b>   |  | 13d. STREET ADDRESS / ZIP CODE<br><b>250 N. Spring Court 21231</b>   |  |   |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>James F. Young</b>  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Lucille watson</b>   |  |   |  |  |  |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>NO</b>  |  | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br><b>213-80-0409</b>  |  | 17. INFORMANT<br>ADDRESS<br><b>Lucille Dixon 250 N. Spring Court</b>  |  |  |  |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Cardiopulmonary Arrest</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <b>Lactate Metabolic Acidosis</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <b>Hepatic Failure Secondary to Cirrhosis</b><br>PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <b>NO</b> |  |  |  |   |  |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>5 minutes</b><br><b>2 days</b><br><b>1 month</b> |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>                 |  |   |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. <b>19</b>  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)   |  |  |  |   |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |  |  |   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>12/26</b> , 19 <b>84</b> , to <b>1/25</b> , 19 <b>85</b> , that (I) (we) last saw the deceased alive on <b>1/25</b> , 19 <b>85</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.  |  |  |  |   |  |  |  |   |  |
| 22b. SIGNATURE<br><b>Henry Parkman</b>   |  |  |  | DEGREE<br><b>MD</b>   |  | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> |  | 22c. DATE SIGNED<br><b>1/25/85</b>  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>Henry Parkman</b>  |  |  |  | 22e. ADDRESS<br><b>Johns Hopkins Hospital</b>   |  |  |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>BURIAL</b>  |  | 23b. DATE<br><b>1/30/85</b>  |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Baltimore Cemetery</b>   |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Baltimore, Md.</b>  |  |   |  |
| 24. FUNERAL DIRECTOR<br>NAME ADDRESS<br><b>Wm C March F/H Inc. 1101 E North Avenue</b>   |  |  |  |   |  | 25a. DATE REC'D BY REGISTRAR<br><b>JAN 28 1985</b>   |  | 25b. REGISTRAR'S SIGNATURE<br><b>e. Davidson-Randall</b>  |  |



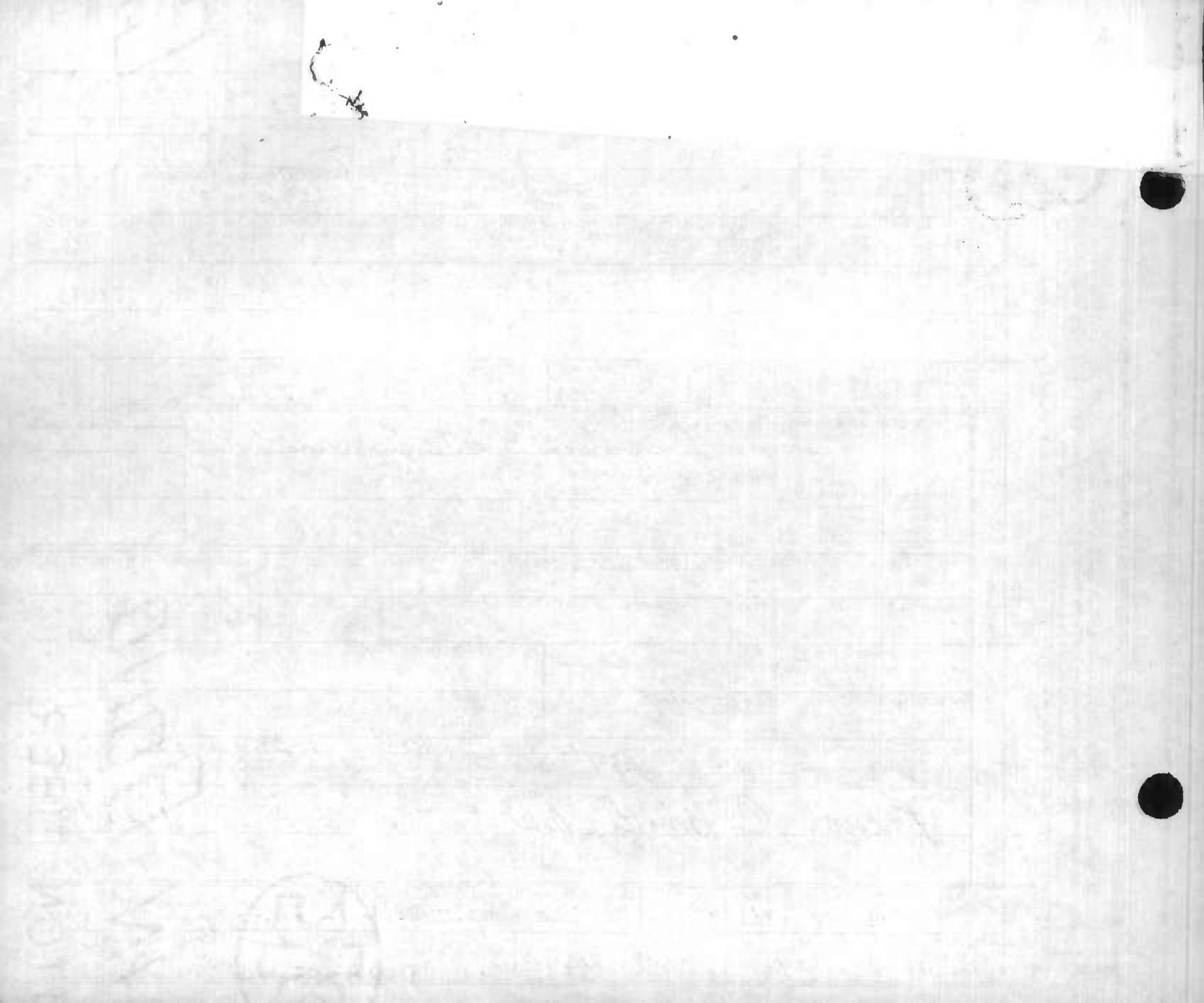
**STATE OF MARYLAND**  
**DEPARTMENT OF HEALTH AND MENTAL HYGIENE**  
**CERTIFICATE OF DEATH**

8 5 0 1 6 8 1

- STATE  
REGISTRAR

REG. NO.

|  |  |   |   |  |  |
|--|--|---|---|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>FIRST MIDDLE LAST<br><b>Lessie Qualls Watson</b>  |  |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>January 25, 1985</b>                                  |  | 2b. HOUR<br>M<br><b>AM</b>   |
| 3. SEX<br><b>Female</b>  | 4. RACE<br><b>Black</b>  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>6 19 01</b>  |   | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>83</b> YRS                                       | IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS<br>HOURS MIN.  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>N.C.</b>   | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>   | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore City</b> MD.                      |  |
| 10. CITY OR TOWN OF DEATH<br><b>Baltimore</b>  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>400 E. 22nd. St.</b> |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)                                |  | 12b. KIND OF BUSINESS OR INDUSTRY  |
| 13a. STATE<br><b>MD</b>  | 13b. COUNTY  | 13c. CITY OR TOWN<br><b>Baltimore</b>   | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | 13e. STREET ADDRESS / ZIP CODE<br><b>400 E. 22nd. St. 21218</b>                        |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST   |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST   |   |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>No</b>  |  | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br><b>213-20-2061</b>   |   | 17. INFORMANT<br>NAME ADDRESS<br><b>Charity Chester<br/>Mary Ward 400 E. 22nd. St.</b> |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Congestive Heart Failure</b><br>DUE TO, OR AS A CONSEQUENCE OF (b)<br>DUE TO, OR AS A CONSEQUENCE OF (c)<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. |  |   |   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH   |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)  |  |   |   |  |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>              | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>8-11- 1980</b>  |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)         |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                      |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>8-11- 1980</b> to <b>1-25- 1985</b> , that (I) (we) last saw the deceased alive on <b>6-1- 1984</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.           |  |   |   |  |  |
| 22b. SIGNATURE<br><b>Percival C. Smith, M.D.</b>   |  | DEGREE<br><b>M.D.</b>   |   | 22c. DATE SIGNED<br><b>1-25-85</b>   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)  |  | 22e. ADDRESS  |   |  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>Burial</b>  |  | 23b. DATE<br><b>2/1/85</b>  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Qualls Family Plot</b>                                 |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Enfield N.C.</b>  |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>Wm. C. March F/H</b>  |  |   | ADDRESS<br><b>1101 E. North Ave.</b>  |  | 25a. DATE REC'D. BY REGISTRAR<br><b>IAN 28 1985</b>  |
|  |  |   | 25b. REGISTRAR'S SIGNATURE<br><b>Davidson</b>   |  |  |





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH   |  |  |  |   | REG. NO.                                     |  |
|--|--|--|--|---|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT) <u>Marian S. Watson</u>  |  |  |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR <u>Jan 30 1985</u> 2b. HOUR <u>9:03 PM</u>                              |  |  |
| 3. SEX<br><u>Female</u>  |  | 4. RACE<br><u>WHITE</u>  |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR <u>06 15 08</u>  |  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><u>Maryland</u>   |  | 7b. CITIZEN OF WHAT COUNTRY?<br><u>U.S.A.</u>  |  | 6. AGE (IN YEARS (LAST BIRTHDAY))<br><u>76</u> YRS. IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN. |  |  |
| 10. CITY OR TOWN OF DEATH<br><u>Baltimore</u>  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><u>Mercy Hospital</u> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><u>Baltimore City</u> MD.   |  |  |
| 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><u>Civil Service</u>   |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><u>U.S. Gov't</u>   |  |   |  |  |
| 13a. STATE<br><u>Maryland</u>  |  | 13b. COUNTY<br><u>21201</u>  |  | 13c. CITY OR TOWN<br><u>Baltimore</u>   |  |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><u>George Scott</u>  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><u>Mamie Swift</u>  |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>             |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><u>Yes</u>   |  | 16b. SOCIAL SECURITY NO.<br><u>WW II 217-14-1936</u>   |  | 17. INFORMANT<br>ADDRESS<br><u>A. Elizabeth Hunter 5708 The Alameda 21239</u>                               |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Gram negative sepsis</u><br>DUE TO, OR AS A CONSEQUENCE OF (b) _____<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO, OR AS A CONSEQUENCE OF (c) _____             |  |  |  |   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) <u>Seizure Disorder</u>  |  |  |  |   |  |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                        |  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><u>P.M. 19</u>  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)                              |  |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |  |
| 22a. I certify that (I) (the hospital) attended the deceased from <u>1/10</u> 19 <u>85</u> , to <u>1/30</u> 19 <u>85</u> , that (I) (we) last saw the deceased alive on <u>1/30</u> 19 <u>85</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (If I (we) did not view the body after death, so state.) |  |  |  |   |  |  |
| 22b. SIGNATURE<br><u>Michael J. Fisher MD</u>  |  |  |  | 22c. DATE SIGNED<br><u>1/30/85</u>  |  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><u>Michael J. Fisher MD</u>   |  |  |  | 22e. ADDRESS<br><u>Mercy Hospital Balto Md 21202</u>  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><u>Cremation</u>   |  | 23b. DATE<br><u>2/1/1985</u>   |  | 23c. NAME OF CEMETERY OR CREMATORY<br><u>Green Mount Crematory</u>  |  |  |
| 24. FUNERAL DIRECTOR<br>NAME<br><u>Walter Brooks Bradley, Inc. Balto., MD 21222</u>  |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><u>Baltimore, Maryland</u>   |  | 25a. DATE REC'D. BY REGISTRAR<br><u>FEB 1 1985</u>  |  |  |
|  |  |  |  | 25b. REGISTRAR'S SIGNATURE<br><u>Jana Davidson-Randall</u>  |  |  |

100% COTTON E18C6

HEAVY DUTY



8 5 0 1 6 8 3

1 - FOR  
STATE  
REGISTRAR

REG. NO.

|   |  |   |  |   |  |   |  |   |  |   |  |   |  |   |  |                                |  |                              |  |
|---|--|---|--|---|--|---|--|---|--|---|--|---|--|---|--|--------------------------------|--|------------------------------|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)   |  | FIRST   |  | MIDDLE  |  | LAST  |  | 2a. DATE OF DEATH   |  | MONTH   |  | DAY                                     |  | YEAR  |  | 2b. HOUR                       |  | A                            |  |
| BABY  |  | BOY   |  | WAYS  |  |   |  | JANUARY 15, 1985  |  |   |  |   |  |   |  | 9:07                           |  | M                            |  |
| 3. SEX  |  | Male  |  | 4. RACE   |  | White   |  | 5. DATE OF BIRTH  |  | MONTH   |  | DAY                                     |  | YEAR  |  | 6. AGE                         |  | (IN YEARS LAST BIRTHDAY)     |  |
|   |  |   |  |   |  |   |  | January 14, 1985  |  |   |  |   |  |   |  | YRS                            |  | 1                            |  |
| 7a. BIRTHPLACE  |  | (STATE OR FOREIGN)  |  | 7b. CITIZEN OF WHAT COUNTRY?                            |  | U.S.A   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH  |  | BALTIMORE CITY                          |  | MD  |  |                                |  |                              |  |
| 10. CITY OR TOWN OF DEATH   |  | BALTIMORE   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION |  | (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)                      |  | JOHNS HOPKINS HOSPITAL  |  | 12a. USUAL OCCUPATION   |  | (TYPE OF WORK FOR MOST OF WORKING LIFE) |  | 12b. KIND OF BUSINESS OR INDUSTRY                                   |  |                                |  |                              |  |
| 13a. USUAL RESIDENCE  |  | (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) |  | 13b. COUNTY   |  | AA Co.  |  | 13c. CITY OR TOWN   |  | Glen Burnie   |  | 13d. INSIDE CITY LIMITS?                |  | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 13e. STREET ADDRESS / ZIP CODE |  | 7518 Holly Brook Rd. (21061) |  |
| 14. FATHER'S NAME   |  | FIRST   |  | MIDDLE  |  | LAST  |  | 15. MOTHER'S MAIDEN NAME  |  | FIRST   |  | MIDDLE                                  |  | LAST  |  |                                |  |                              |  |
|   |  | James   |  | R.  |  | Ways  |  |   |  | Dawne   |  |   |  | Wiles   |  |                                |  |                              |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?  |  | (YES, NO OR UNKNOWN)  |  | 16b. SOCIAL SECURITY NO.                                |  | (IF YES, GIVE WAR OR DATES)   |  | 17. INFORMANT   |  | ADDRESS   |  |   |  |   |  |                                |  |                              |  |
|   |  | No  |  |   |  | ---   |  | James R. Ways   |  | 7518 Holly Brook Rd (21061)   |  |   |  |   |  |                                |  |                              |  |
| 18. CAUSE OF DEATH  |  | (Enter only one cause per line for (a), (b), and (c).)                  |  | PART I. DEATH WAS CAUSED BY:                            |  | IMMEDIATE CAUSE (a)   |  | Cardiopulmonary arrest  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH  |  | 5 min                                   |  |   |  |                                |  |                              |  |
|   |  |   |  |   |  | DUE TO, OR AS A CONSEQUENCE OF                                      |  | (b) Severe respiratory distress   |  |   |  | 12 h.                                   |  |   |  |                                |  |                              |  |
|   |  |   |  |   |  | DUE TO, OR AS A CONSEQUENCE OF                                      |  | (c) Prematurity   |  |   |  | 12 h.                                   |  |   |  |                                |  |                              |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) |  | Possible sepsis   |  |   |  |   |  |   |  |   |  |   |  |   |  |                                |  |                              |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                        |  | 20a. AUTOPSY?   |  | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?                        |  | YES <input type="checkbox"/> NO <input type="checkbox"/>                                      |  |   |  |   |  |                                |  |                              |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH                       |  | (IF EITHER, NOTIFY MEDICAL EXAMINER)                                    |  | 21b. TIME OF INJURY                                     |  | HOUR A.M. MONTH DAY YEAR  |  | 21c. HOW INJURY OCCURRED  |  | (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)   |  |   |  |   |  |                                |  |                              |  |
|   |  |   |  |   |  | P.M. 19   |  |   |  |   |  |   |  |   |  |                                |  |                              |  |
| 21d. INJURY OCCURRED  |  | 21e. PLACE OF INJURY  |  | 21f. LOCATION   |  | STREET  |  | CITY OR TOWN  |  | COUNTY  |  | STATE                                   |  |   |  |                                |  |                              |  |
| WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>   |  | (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                          |  |   |  |   |  |   |  |   |  |   |  |   |  |                                |  |                              |  |
| 22a. I certify that (I) (this hospital) attended the deceased from  |  | 1/14  |  | 19  |  | 85  |  | to  |  | 1/15  |  | 19                                      |  | 85  |  | that (I) (we) lost             |  |                              |  |
|   |  | saw the deceased alive on   |  | 1/15  |  | 19  |  | 85  |  | and that in (my) (our) opinion death occurred on the date and hour and from the causes stated |  |   |  |   |  |                                |  |                              |  |
| 22b. SIGNATURE  |  | 22c. DEGREE   |  | 22d. DATE SIGNED  |  | 1/15/85   |  |   |  |   |  |   |  |   |  |                                |  |                              |  |
| 22e. PHYSICIAN'S NAME   |  | (TYPE OR PRINT)   |  | 22f. ADDRESS  |  | 43 Johns Hopkins Hospital   |  |   |  |   |  |   |  |   |  |                                |  |                              |  |
| 23a. BURIAL, CREMATION, REMOVAL   |  | (SPECIFY)   |  | 23b. DATE   |  | Jan 18, 1985  |  | 23c. NAME OF CEMETERY OR CREMATORY  |  | Glen Haven Cem  |  | 23d. LOCATION                           |  | CITY OR TOWN  |  | COUNTY                         |  | STATE                        |  |
|   |  | Burial  |  |   |  |   |  |   |  |   |  | Glen Burnie, Maryland                   |  |   |  |                                |  |                              |  |
| 24. FUNERAL DIRECTOR  |  | NAME  |  | ADDRESS   |  | A. Alan Seitz Funeral Home 3818 Roland Ave                          |  | 25a. DATE REC'D. BY REGISTRAR   |  | 25b. REGISTRAR'S SIGNATURE  |  | JAN 22 1985                             |  |   |  |                                |  |                              |  |

TO HOSPITAL OR ATTENDING PHYSICIAN. The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

[illegible]

01/14/85

MEDICAL CERTIFICATION

BP\_\_\_\_\_

RECEIVED  
JAN 12 1964



UNIT NO. 1000

UNIT NO. 1000

UNIT NO. 1000

UNIT NO. 1000

UNIT NO. 1000

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200 SS PAL

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8501684

1- FOR  
STATE  
REGISTRAR

REG. NO.

|   |  |   |   |   |                                       |  |   |   |   |  |  |
|---|--|---|---|---|---------------------------------------|--|---|---|---|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>GEORGE WEAVER</b>                                  |  |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>1 24 85</b> |   |                                       | 2b. HOUR<br><b>12 PM</b>   |   |   |   |  |  |
| 3. SEX<br><b>MALE</b>   |  | 4. RACE<br><b>WHITE</b>   |   | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>July 8, 1896</b>   |                                       | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>88yrs. YRS</b>                               |   | # UNDER 1 YEAR<br>MONTHS DAYS HOURS MIN.  |   |  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Maryland</b>                              |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>   |   | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |                                       | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>BALTO. CITY MD.</b>                     |   |   |   |  |  |
| 10. CITY OR TOWN OF DEATH<br><b>BALTO.</b>  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Francis Scott Mason F. Lord Key</b> |   |   |                                       | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Retired</b> |   | 12b. KIND OF BUSINESS OR INDUSTRY   |   |  |  |
| 13a. STATE<br><b>Maryland</b>   |  |   | 13b. COUNTY<br><b>Baltimore</b>                       |   | 13c. CITY OR TOWN<br><b>Baltimore</b> |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |   | 13e. STREET ADDRESS / ZIP CODE<br><b>1507 W. 36th St. 21211</b> |  |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>George W. Weaver</b>                         |  |   |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>unk</b>   |                                       |  |   | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)<br><b>No ---</b> |   | 16b. SOCIAL SECURITY NO.<br><b>212-07-5246</b> |  |
| 17. INFORMANT<br>ADDRESS<br><b>George J. Weaver 1507 W. 36th St. Baltimore, Md. 21211</b> |  |   |   |   |                                       |  |   |   |   |  |  |

## 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) **PNEUMONIA**

DUE TO, OR AS A CONSEQUENCE OF

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last

(b) **ASPIRATION**

DUE TO, OR AS A CONSEQUENCE OF

(c) **CVA**

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a.

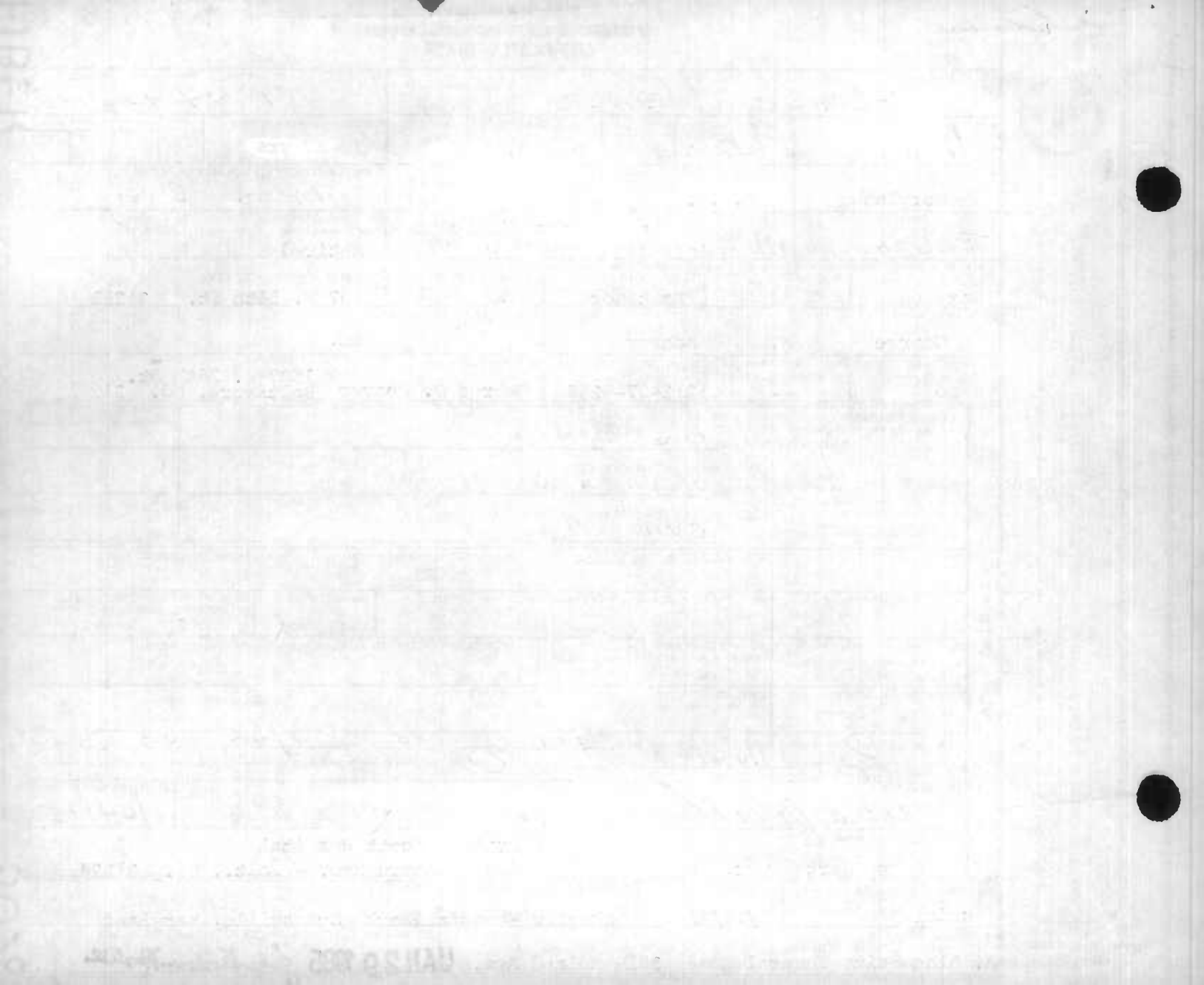
|  |  |  |  |  |  |  |  |
|--|--|--|--|--|--|--|--|
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                       |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>      |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18: PART I OR PART 2)         |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                      |  |  |  |
| 22a. I certify that (I) (his hospital) attended the deceased from <b>1/17 1985</b> to <b>1/24 1985</b> , that (I) (we) lost<br>saw the deceased alive on <b>1/24/85</b> 19____, and that (my) (our) opinion death occurred on the date and hour and from the causes stated<br>above, (I) (we) (did) (did not) view the body after death. |  |  |  |  |  |  |  |
| 22b. SIGNATURE<br><b>Debra Wertheimer</b>  |  |  |  | DEGREE<br><b>MD</b>  |  | 22c. DATE SIGNED<br><b>1/24/85</b>   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>Debra Wertheimer, MD</b>   |  |  |  | 22e. ADDRESS<br><b>Francis Scott Hospital<br/>4940 Eastern Ave. - Balt., Md. 21224</b> |  |  |  |

|  |  |                             |  |  |  |   |  |
|--|--|-----------------------------|--|--|--|---|--|
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>Burial</b>                                 |  | 23b. DATE<br><b>1/26/85</b> |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Lakeview Memorial Park</b>            |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Sykesville, Maryland</b> |  |
| 24. FUNERAL DIRECTOR<br>NAME ADDRESS<br><b>A. Alan Seitz Funeral Home 3818 Roland Ave.</b> |  |                             |  | 25a. DATE REC'D. BY REGISTRAR 25b. REGISTRAR'S SIGNATURE<br><b>JAN 29 1985</b> |  |   |  |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Then please remove carbon copies. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon-copy. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 5 0 1 6 8 5

1- FOR  
STATE  
REGISTRAR

REG. NO.

|  |  |                        |   |  |  |  |  |  |   |  |  |   |  |  |
|--|--|------------------------|---|--|--|--|--|--|---|--|--|---|--|--|
| 1 DECEASED NAME<br>(TYPE OR PRINT) <b>JULIUS S. WEBB</b>   |  |                        | 2a DATE OF DEATH<br>MONTH <b>01</b> DAY <b>30</b> YEAR <b>1985</b>  |  |  | 2b HOUR<br><b>5:14 P.M.</b>  |  |  |   |  |  |   |  |  |
| 3 SEX<br><b>MALE</b>   |  | 4 RACE<br><b>Black</b> |   | 5. DATE OF BIRTH<br>MONTH <b>01</b> DAY <b>14</b> YEAR <b>05</b>       |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>79</b> YRS.  |  | IF UNDER 1 YEAR<br>MONTHS <b>00</b> DAYS <b>00</b>                                   |   | IF UNDER 24 HRS.<br>HOURS <b>00</b> MIN. <b>00</b>   |  |   |  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN)<br><b>N. Carolina</b>  |  |                        | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>  |  |  | 8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>                                 |  |  |   |  |  |   |  |  |
| 9 BALTIMORE CITY OR COUNTY OF DEATH<br><b>BAITO. CITY</b>  |  |                        | MD.   |  |  |  |  |  |   |  |  |   |  |  |
| 10 CITY OR TOWN OF DEATH<br><b>Baltimore</b>   |  |                        | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>MUTHERAN HOSPITAL</b> |  |  |  |  |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>RETIRED</b>              |  |  | 12b. KIND OF BUSINESS OR INDUSTRY                                 |  |  |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)  |  |                        |   |  |  |  |  |  |   |  |  |   |  |  |
| 13a. STATE<br><b>MD</b>  |  |                        | 13b. COUNTY<br><b>BALTO.</b>  |  |  | 13c. CITY OR TOWN<br><b>BALTO.</b>   |  |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |  | 13e. STREET ADDRESS / ZIP CODE<br><b>1816 Moreland Ave. 21216</b> |  |  |
| 14 FATHER'S NAME<br>FIRST <b>Julius</b> MIDDLE <b>Webb</b> LAST <b>Webb</b>  |  |                        |   |  |  | 15 MOTHER'S MAIDEN NAME<br>FIRST <b>-</b> MIDDLE <b>-</b> LAST <b>-</b>  |  |  |   |  |  |   |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>NO</b>  |  |                        |   | 16b. SOCIAL SECURITY NO.<br><b>219-32-5301</b>                         |  |  |  | 17. INFORMANT<br>ADDRESS<br><b>Doris Sewell 1816 Moreland Avenue</b>                 |   |  |  |   |  |  |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Myocardial Infarction</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) _____<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last<br>(c) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(d) _____<br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |  |                        |   |  |  |  |  |  |   |  |  |   |  |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a  |  |                        |   |  |  |  |  |  |   |  |  |   |  |  |
| 19a. DATE OF OPERATION   |  |                        |   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                       |  |  |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |   | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |   |  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER NOTIFY MEDICAL EXAMINER)  |  |                        |   | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. <b>19</b>      |  |  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)       |   |  |  |   |  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>   |  |                        |   | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) |  |  |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                    |   |  |  |   |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>JAN 14 1985</b> to <b>1/31 1985</b> , that (I) (we) lost<br>saw the deceased alive on <b>1/31/85</b> , 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated<br>above, (I) (we) (did) (did not) view the body after death.   |  |                        |   |  |  |  |  |  |   |  |  |   |  |  |
| 22b. SIGNATURE<br><b>Mark Dan</b>  |  |                        |   |  |  | DEGREE <b>MD</b><br>ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL STAFF <input type="checkbox"/><br>DIRECTOR <input type="checkbox"/> PHYSICIAN <input type="checkbox"/> |  |  | 22c. DATE SIGNED<br><b>2/1/85</b>   |  |  |   |  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>MARK DAN</b>   |  |                        |   |  |  | 22e. ADDRESS<br><b>MD 5101 S. BAY MATTHEW CC MD</b>  |  |  |   |  |  |   |  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>BURIAL</b>  |  |                        |   | 23b. DATE<br><b>2/7/85</b>   |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>King Memorial Park</b>  |  |  |   | 23d. LOCATION<br>CITY OR TOWN <b>Randallstown</b> COUNTY <b>2093</b> STATE <b>Md.</b>                                      |  |   |  |  |
| 24. FUNERAL DIRECTOR<br><b>Wm C March F/H Inc. 1101 E North Ave.</b>   |  |                        |   |  |  | 25a. DATE REC'D. BY REGISTRAR<br><b>FEB 5 1985</b>   |  | 25b. REGISTRAR'S SIGNATURE<br><b>Richardson-Randall</b>                              |   |  |  |   |  |  |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 2 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 3 and 4 should be detached for use on the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with your death certificate with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked as item 18, the cause of death, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE   |  |   |   | 8 5 0 1 6 8 6  |  |
|--|--|---|---|--|--|
| 1- FOR STATE REGISTRAR   |  |   |   | REG. NO.   |  |
| 1. DECEASED NAME (TYPE OR PRINT)<br>FIRST MIDDLE LAST<br>Anna E. Weber   |  |   | 2a. DATE OF DEATH MONTH DAY YEAR<br>1-22-85   |  | 2b. HOUR<br>12 <sup>35</sup> P.M.              |
| 3. SEX<br>Female   | 4. RACE<br>White   | 5. DATE OF BIRTH MONTH DAY YEAR<br>1 21 1910  |   | 6. AGE (IN YEARS LAST BIRTHDAY)<br>75 YRS.                                     |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Maryland  | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.A.   | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Baltimore City MD.                     |  |
| 10. CITY OR TOWN OF DEATH<br>Baltimore   | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>Francis Scott Key Med.Center |   | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Sales Clerk                    |  | 12b. KIND OF BUSINESS OR INDUSTRY<br>Gem Store |
| 13a. STATE<br>Maryland   |  | 13b. CITY OR TOWN<br>Baltimore  | 13c. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 13d. STREET ADDRESS / ZIP CODE<br>906 Wise Avenue 21222                        |  |
| 14. FATHER'S NAME FIRST MIDDLE LAST<br>John H. Grace   |  | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST<br>Florence M. Metzger   |   |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)<br>NO  |  | 16b. SOCIAL SECURITY NO.<br>215-05-7338   |   | 17. INFORMANT ADDRESS<br>Ralph F. Weber Same as 13e                            |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>cardiorespiratory arrest</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last<br>(b) <u>arrhythmias</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <u>dilated cardiomyopathy</u> |  |   |   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH   |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)   |  |   |   |  |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>      |  |
| 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>   |  |   |   |  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR<br>P.M. 19   |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |   | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE                                 |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>1/17</u> , 19 <u>85</u> , to <u>1/22</u> , 19 <u>85</u> , that (I) (we) last saw the deceased alive on <u>1/22</u> , 19 <u>85</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.                                   |  |   |   |  |  |
| 22b. SIGNATURE<br><u>Charles B. Treasure II</u>  |  | DEGREE<br>MD<br>ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>  |   | 22c. DATE SIGNED<br>1/22/85  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>Charles B. Treasure II  |  | 22e. ADDRESS<br>Francis Scott Key Hospital Balto, MD  |   |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br>Burial  |  | 23b. DATE<br>1/25/1985  |   | 23c. NAME OF CEMETERY OR CREMATORY<br>Parkwood                                 |  |
| 23d. LOCATION CITY OR TOWN COUNTY STATE<br>Baltimore Maryland  |  |   |   |  |  |
| 24. FUNERAL DIRECTOR Duda-Ruck, Inc.<br>NAME ADDRESS<br>7922 Wise Avenue Dundalk, MD. 21222  |  | 25a. DATE REC'D. BY REGISTRAR<br>JAN 25 1985  |   | 25b. REGISTRAR'S SIGNATURE<br><u>[Signature]</u>                               |  |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

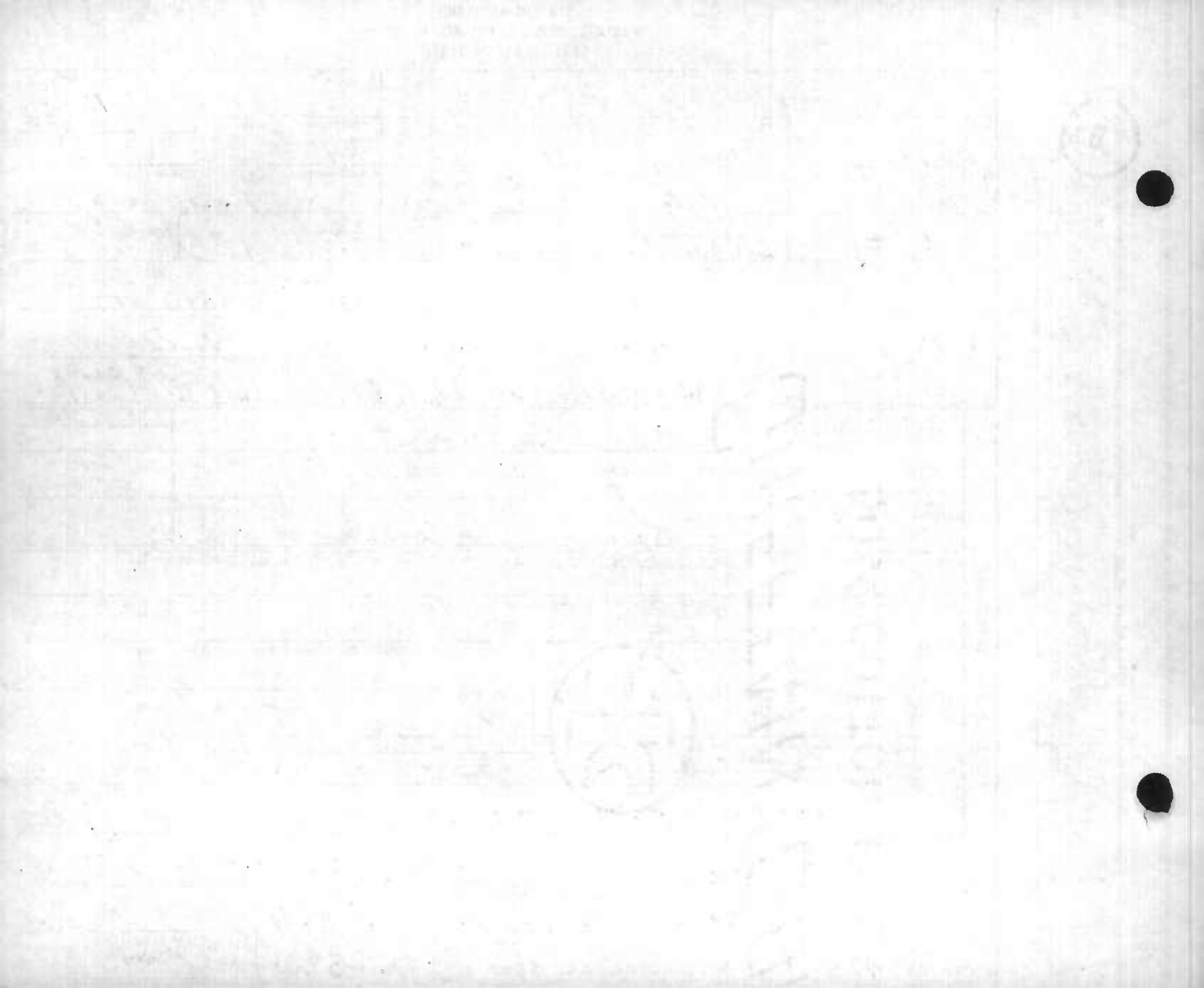
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of once.

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|  |                              |  |  |  |   |  |  |                                   |  |
|--|------------------------------|--|--|--|---|--|--|-----------------------------------|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)  |                              | FIRST MIDDLE LAST  |  | 2a. DATE OF DEATH  |   | MONTH DAY YEAR   |  | 2b. HOUR                          |  |
| James WEBSTER  |                              |  |  | 01 19 85   |   | 11:25p   |  | M                                 |  |
| 3 SEX  | 4 RACE                       | 5. DATE OF BIRTH   |  | 6 AGE (IN YEARS LAST BIRTHDAY)   |   | IF UNDER 1 YEAR  |  | IF UNDER 24 HRS                   |  |
| male   | Negro                        | MONTH DAY YEAR<br>11 11 21   |  | 64   |   | MONTHS DAYS  |  | HOURS MIN.                        |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)  | 7b. CITIZEN OF WHAT COUNTRY? | 8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9 BALTIMORE CITY OR COUNTY OF DEATH  |   |  |  |                                   |  |
| M.D.   | U.S.A.                       |  |  | Baltimore city MD.   |   |  |  |                                   |  |
| 10. CITY OR TOWN OF DEATH  |                              | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)  |  |  |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE) |  | 12b. KIND OF BUSINESS OR INDUSTRY |  |
| city   |                              | Lincoln Convalescent Center  |  |  |   | Retired  |  |                                   |  |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)  |                              |  |  |  | 13d. INSIDE CITY LIMITS?  |  | 13e. STREET ADDRESS  |                                   |  |
| 13a. STATE   |                              |  |  |  | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | # 21218  |                                   |  |
| 13b. COUNTY  |                              |  |  |  | BALTO   |  | 1613 CARSAWELL ST  |                                   |  |
| 14 FATHER'S NAME   |                              | 15 MOTHER'S MAIDEN NAME  |  |  |   |  |  |                                   |  |
| FIRST MIDDLE LAST  |                              | FIRST MIDDLE LAST  |  |  |   |  |  |                                   |  |
| Daniel Webster   |                              | Ruth PARKS   |  |  |   |  |  |                                   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)   |                              | 16b. SOCIAL SECURITY NO.   |  | 17 INFORMANT   |   | ADDRESS  |  |                                   |  |
| NO   |                              | 215-12-5754  |  | Mrs. Emily Benston   |   | 1613 CARSAWELL ST. # 21218                                       |  |                                   |  |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) Cardiac arrest<br>DUE TO, OR AS A CONSEQUENCE OF arteriosclerotic cardiovascular disease<br>(b) COPD<br>DUE TO, OR AS A CONSEQUENCE OF peripheral vascular disease<br>(c)<br>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) |                              |  |  |  |   |  |  |                                   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| MEDICAL CERTIFICATION  |                              |  |  |  |   |  |  |                                   |  |
| 19a. DATE OF OPERATION   |                              | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  |  | 20a. AUTOPSY?   |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? |                                   |  |
|  |                              |  |  |  | YES <input type="checkbox"/> NO <input type="checkbox"/>            |  | YES <input type="checkbox"/> NO <input type="checkbox"/>       |                                   |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |                              | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) |   |  |  |                                   |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK   |                              | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                              |   |  |  |                                   |  |
|  |                              |  |  | 1/21 82 to 1/19 85   |   |  |  |                                   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from 1/19 85, and that in (my) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.   |                              |  |  |  |   |  |  |                                   |  |
| 22b. SIGNATURE   |                              | DEGREE   |  | 22c. DATE SIGNED   |   |  |  |                                   |  |
| Kuang-Yen Huang  |                              | M.D.   |  | 1/19 85  |   |  |  |                                   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)  |                              | 22e. ADDRESS   |  |  |   |  |  |                                   |  |
| KUANG-YEN HUANG  |                              | BON Secours Hospital   |  |  |   |  |  |                                   |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)   |                              | 23b. DATE  |  | 23c. NAME OF CEMETERY OR CREMATORY   |   | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE                       |  |                                   |  |
| Burial   |                              | 1-24-85  |  | Eastview Cem.  |   | BALTO. MD.   |  |                                   |  |
| 24 FUNERAL DIRECTOR<br>NAME  |                              | 44 ADDRESS   |  | 25a. DATE REC'D. BY REGISTRAR  |   | 25b. REGISTRAR'S SIGNATURE                                       |  |                                   |  |
| BEHS F/H 1129 N. CAROLINE ST.  |                              |  |  | JAN 23 1985  |   | John Davidson  |  |                                   |  |

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STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|   |  |   |  |   |  |  |  |  |  |
|---|--|---|--|---|--|--|--|--|--|
| 1. FOR<br>STATE<br>REGISTRAR  |  |   | 2a. DATE OF DEATH MONTH DAY YEAR                                       |   |  | 2b. HOUR P M   |  |  |  |
| 1. DECEASED NAME FIRST MIDDLE LAST<br>MILDRED C. WEES   |  |   | JANUARY 31, 1985   |   |  | 9:20 AM  |  |  |  |
| 3. SEX<br>Female  |  | 4. RACE<br>Black  |  | 5. DATE OF BIRTH MONTH DAY YEAR<br>11 24 26   |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br>58 YRS  |  | 7. IF UNDER 1 YEAR IF UNDER 24 HRS.<br>MONTHS DAYS HOURS MIN.  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Maryland   |  | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.A.  |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>BALTIMORE CITY MD.   |  |  |  |
| 10. CITY OR TOWN OF DEATH<br>BALTIMORE  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>THE JOHNS HOPKINS HOSPITAL |  |   |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)   |  | 12b. KIND OF BUSINESS OR INDUSTRY  |  |
| 13. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)   |  |   |  |   |  |  |  |  |  |
| 13a. STATE<br>Maryland  |  | 13b. COUNTY   |  | 13c. CITY OR TOWN<br>Baltimore  |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>  |  | 13e. STREET ADDRESS / ZIP CODE<br>1749 Montpelier St. 21218  |  |
| 14. FATHER'S NAME FIRST MIDDLE LAST<br>Emmett Wees  |  |   |  | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST<br>Margaret Quilla   |  |  |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)<br>NO  |  |   |  | 16b. SOCIAL SECURITY NO.<br>216-20-6665   |  | 17. INFORMANT ADDRESS<br>Henry Veney 1749 Montpelier Street  |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for 1a, 1b, and 1c)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>CARDIO PULMONARY ARREST</u><br>DUE TO, OR AS A CONSEQUENCE OF (b) <u>SEPSIS</u><br>DUE TO, OR AS A CONSEQUENCE OF (c) <u>CANCER</u>   |  |   |  |   |  |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><u>4 minutes</u><br><u>2 weeks</u><br><u>6 months</u>                      |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: a  |  |   |  |   |  |  |  |  |  |
| 19a. DATE OF OPERATION  |  |   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                       |   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  |   | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR<br>P.M. 19                |   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)   |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK  |  |   | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) |   |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE  |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>12/28</u> , 19 <u>84</u> , to <u>1/31/85</u> , 19 <u>85</u> , that (I) (we) last saw the deceased alive on <u>1/31/85</u> , 19 <u>85</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. |  |   |  |   |  |  |  |  |  |
| 22b. SIGNATURE<br><u>Edith Fraser Keith MD</u>  |  |   |  |   |  | DEGREE<br>ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> |  | 22c. DATE SIGNED<br><u>1/31/85</u>   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>EDITH FRASER KEITH   |  |   |  |   |  | 22e. ADDRESS<br>THE JOHNS HOPKINS HOSPITAL<br>600 N. WOLFE ST. BALTO. MD. 21205  |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br>BURIAL  |  |   | 23b. DATE<br>2/5/85  |   | 23c. NAME OF CEMETERY OR CREMATORY<br>Mount Calvary Cem. |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Anne Arundel Co, Md. |  |  |
| 24. FUNERAL DIRECTOR<br>NAME ADDRESS<br>Wm C March F/H Inc. 1101 E North Avenue   |  |   |  |   |  | 25a. DATE REC'D. BY REGISTRAR<br>FEB 4 1985  |  | 25b. REGISTRAR'S SIGNATURE<br><u>Jehia Davidson-Randall</u>  |  |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed without delay after death. Pages 4 may be retained by the hospital or attending physician. The law requires that the death certificate be executed without delay after death. Pages 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please return it to the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

THE UNIVERSITY OF CHICAGO  
LIBRARY



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200-110-1802



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified and a post-mortem examination required.

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 5 0 1 6 8 9

1- FOR  
STATE  
REGISTRAR

REG. NO.

|   |  |   |   |   |  |   |  |
|---|--|---|---|---|--|---|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>FIRST MIDDLE LAST<br><b>EDWARD James WEGLEIN</b>                                 |  |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>1 27 85</b> |   |  | 2b. HOUR<br><b>0110</b> M   |  |
| 3. SEX<br><b>MALE</b>   |  | 4. RACE<br><b>WHITE</b>   |   | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>7 4 23</b>   |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>61</b> YRS.                                       |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>MD</b>  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>  |   | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore City</b> MD.                       |  |
| 10. CITY OR TOWN OF DEATH<br><b>Baltimore</b>   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>South Baltimore General</b> |   |   |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Mail Handler</b> |  |
| 12b. KIND OF BUSINESS OR INDUSTRY<br><b>U.S. Post Office</b>  |  |   |   |   |  |   |  |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE<br><b>MD</b> |  |   |   | 13b. COUNTY<br><b>A.A.</b>  |  | 13c. CITY OR TOWN<br><b>PASADENA</b>  |  |
| 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                         |  | 13e. STREET ADDRESS / ZIP CODE<br><b>1218 June way 21122</b>  |   |   |  |   |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Michael WEGLEIN</b>  |  |   |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE<br><b>Anna Unknown</b>   |  |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>Yes</b>                                      |  | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE YEAR OF DATES)<br><b>WW II 213-18-6064</b>  |   | 17. INFORMANT<br>ADDRESS<br><b>Patricia Ramsey 1218 Juneway Pasadena, Md</b>  |  |   |  |

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)  
PART 1. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a)

**CARDIO PULMONARY ARREST**

DUE TO, OR AS A CONSEQUENCE OF

Conditions, if any, which  
gave rise to immediate  
cause (a), stating the  
underlying cause last.

(b) **METASTATIC Squamous Cell CA**

DUE TO, OR AS A CONSEQUENCE OF

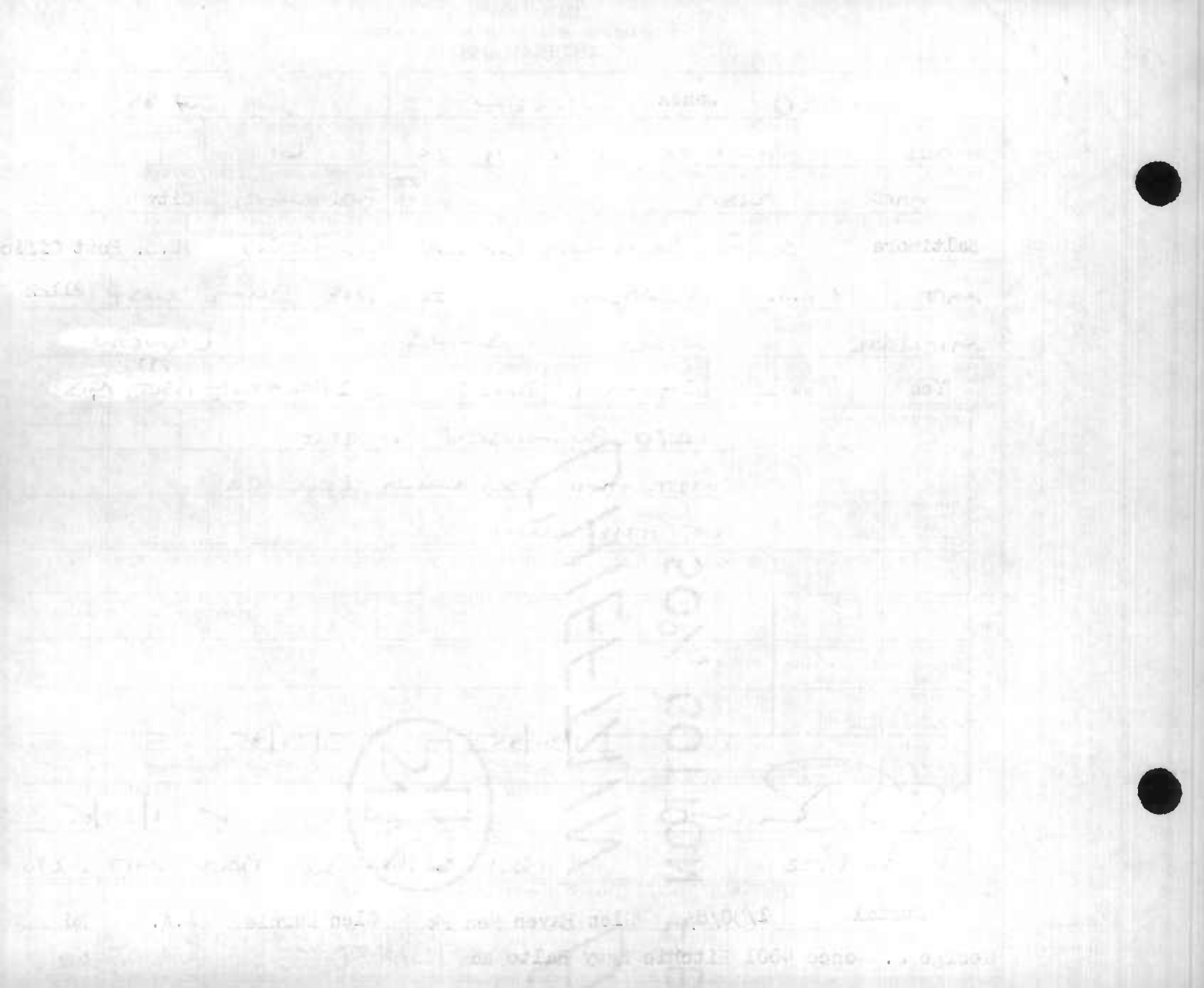
(c) **OF THE LUNG**APPROXIMATE INTERVAL  
BETWEEN ONSET AND DEATH

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)

MEDICAL CERTIFICATION

|   |  |  |  |  |  |   |  |
|---|--|--|--|--|--|---|--|
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                       |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>      |  | 20b. IF YES, WERE FINDINGS USED<br>IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19             |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) |  |   |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                              |  |   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>1/24/85</b> 19 to <b>1/27/85</b> 19, that (I) (we) lost<br>(low the decedent alive on above, (I) (we) did) (did not) view the body after death. 19, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated |  |  |  |  |  |   |  |
| 22b. SIGNATURE<br><b>[Signature]</b>  |  |  |  | DEGREE   |  | 22c. DATE SIGNED<br><b>1/27/85</b>  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>D. DE PREEZ</b>   |  |  |  | 22e. ADDRESS<br><b>3001 S. Hanover Balt MD 21230</b>                           |  |   |  |

|  |  |                             |  |   |  |  |  |
|--|--|-----------------------------|--|---|--|--|--|
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>Burial</b>            |  | 23b. DATE<br><b>1/30/85</b> |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Glen Haven Mem Pk</b>  |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Glen Burnie A.A. Md</b> |  |
| 24. FUNERAL DIRECTOR<br><b>George J. Gonca 4001 Ritchie Hwy Balto Md</b> |  |                             |  | 25a. DATE REC'D. BY REGISTRAR 25b. REGISTRAR'S SIGNATURE<br><b>JAN 30 1985 Julia Davidson-Randall</b> |  |  |  |



REG NO

25a. DATE REC'D. BY REGISTRAR 25b. REGISTRAR  
JAN 20 1985 *Julia Davidson-Henderson*

BP\_\_\_\_\_

DHMH - 17

(VR A15 ME (5))

COPIES TO BE MADE

ORIGINAL

JAN 20 1963

BP

DHMH - 16 50M 4/83  
(VRA 15, 4)

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4, may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH  |  |   |  |   |                              |   |  |  |  | REG. NO.                                     |  |
|---|--|---|--|---|------------------------------|---|--|--|--|--|--|
| 1. FOR STATE REGISTRAR  |  |   |  |   | 2a. DATE OF DEATH            |   |  |  |  | 2b. HOUR                                     |  |
| 1. DECEASED NAME (TYPE OR PRINT) <b>BESSIE 'L. WEINACHT</b>   |  |   |  |   | MONTH DAY YEAR <b>1-8-85</b> |   |  |  |  | 1:57 P.M.                                    |  |
| 3. SEX <b>Female</b>  |  | 4. RACE <b>White</b>  |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR <b>1 18 1897</b>   |                              | 6. AGE (IN YEARS LAST BIRTHDAY) <b>87</b> YRS.  |  | IF UNDER 1 YEAR<br>MONTHS DAYS   |  | IF UNDER 24 HRS.<br>HOURS MIN.               |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>North Carolina</b>   |  | 7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>   |                              | 9. BALTIMORE CITY OR COUNTY OF DEATH <b>Baltimore City</b> MD.                                      |  |  |  |  |  |
| 10. CITY OR TOWN OF DEATH <b>Baltimore</b>  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Lutheran Hospital 21216</b> |  |   |                              | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Retired</b>                        |  | 12b. KIND OF BUSINESS OR INDUSTRY  |  |  |  |
| 13a. STATE <b>Maryland</b>  |  | 13b. COUNTY <b>--</b>   |  | 13c. CITY OR TOWN <b>Baltimore</b>  |                              | 13d. INSIDE CITY LIMITS? <b>YES</b> <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 13e. STREET ADDRESS / ZIP CODE <b>3347 Paine Street 21211</b>  |  |  |  |
| 14. FATHER'S NAME<br>FIRST <b>Henry</b> MIDDLE <b>H.D.</b> LAST <b>Quick</b>  |  |   |  | 15. MOTHER'S MAIDEN NAME<br>FIRST <b>(unknown)</b> MIDDLE <b>(unknown)</b> LAST <b>(unknown)</b>  |                              |   |  |  |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>No</b>   |  | 16b. SOCIAL SECURITY NO. <b>213-10-3777A</b>  |  | 17. INFORMANT ADDRESS <b>Mr. Luther Butler 1024 W. 38th St. 21211</b>   |                              |   |  |  |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Respiratory failure - Sepsis</b><br>DUE TO, OR AS A CONSEQUENCE OF (b) <b>Bilateral pneumonia</b><br>DUE TO, OR AS A CONSEQUENCE OF (c) <b></b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. |  |   |  |   |                              |   |  |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: a  |  |   |  |   |                              |   |  |  |  |  |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  |   |                              | 20a. AUTOPSY? <b>YES</b> <input type="checkbox"/> NO <input checked="" type="checkbox"/>            |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? <b>YES</b> <input type="checkbox"/> NO <input type="checkbox"/> |  |  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)  |                              |   |  |  |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK  |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |                              |   |  |  |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>12/28</b> , 19 <b>84</b> , to <b>1/8</b> , 19 <b>85</b> , that (I) (we) last saw the deceased alive on <b>1/8</b> , 19 <b>85</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.                     |  |   |  |   |                              |   |  |  |  |  |  |
| 22b. SIGNATURE <b>Bich T Duong</b>  |  |   |  | DEGREE <b>M.D.</b> ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> |                              |   |  | 22c. DATE SIGNED <b>1/8/85</b>   |  |  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>BICH T DUONG</b>   |  |   |  | 22e. ADDRESS <b>LUTHERAN HOSPITAL</b>   |                              |   |  |  |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>   |  | 23b. DATE <b>1/11/85</b>  |  | 23c. NAME OF CEMETERY OR CREMATORY <b>Lorraine Park Cem.</b>  |                              | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE <b>Baltimore Maryland</b>                                |  |  |  |  |  |
| 24. FUNERAL DIRECTOR<br>NAME <b>A. Alan Seitz</b> ADDRESS <b>3818 Roland Ave. 21211</b>   |  |   |  | 25a. DATE REC'D. BY REGISTRAR <b>JAN 11 1985</b>  |                              |   |  | 25b. REGISTRAR'S SIGNATURE <b>Julia Davidson-Randall</b>   |  |  |  |

3

CHIEF OF POLICE



STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 5 0 1 6 9 2

FOR  
1- STATE  
REGISTRAR

REG. NO.

|   |                         |   |  |   |   |
|---|-------------------------|---|--|---|---|
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>James E. Wells SR.</b>   |                         |   | 2a. DATE OF DEATH<br>MONTH <b>1</b> DAY <b>31</b> YEAR <b>85</b> |   | 2b. HOUR<br><b>7:30</b> <sup>M</sup>                            |
| 3. SEX<br><b>male</b>   | 4. RACE<br><b>Black</b> | 5. DATE OF BIRTH<br>MONTH <b>2</b> DAY <b>5</b> YEAR <b>35</b>  |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>49</b>  |   |
| 7b. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>USA Md.</b>   |                         | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>  |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> |   |
| 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>BALTO. CITY</b> MD.  |                         | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>mechanical ELEC. repairer</b>  |  |   |   |
| 10. CITY OR TOWN OF DEATH<br><b>Baltimore</b>   |                         | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Good Samaritan Hospital of Balto.</b> |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>None</b>  |   |
| 13. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE <b>Maryland</b> 13b. COUNTY <b>Balto County</b> 13c. CITY OR TOWN <b>Glen Arm</b>   |                         |   |  |   |   |
| 14. FATHER'S NAME<br>FIRST <b>JAMES</b> MIDDLE <b>T</b> LAST <b>WELLS</b>   |                         | 15. MOTHER'S MAIDEN NAME<br>FIRST <b>Sarah</b> MIDDLE <b>Hartgrove</b> LAST <b>WELLS</b>  |  |   |   |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) <b>NO</b>  |                         | 16b. SOCIAL SECURITY NO.<br><b>215-32-17006</b>   |  | 17. INFORMANT<br>ADDRESS <b>JAMES E. WELLS JR S/A</b>   |   |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Cerebro-respiratory death 2° Hyperkalemia</b><br>DUE TO, OR AS A CONSEQUENCE OF (b) <b>Renal CA with multiple metastases</b><br>DUE TO, OR AS A CONSEQUENCE OF (c) <b>to liver and lungs.</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. |                         |   |  |   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>17 days.</b> |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a  |                         |   |  |   |   |
| 19a. DATE OF OPERATION  |                         | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>   |   |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |                         | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. <b>19</b>   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)   |   |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK  |                         | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |   |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>1/31/85</b> , 19 <b>85</b> , to <b>1/31</b> , 19 <b>85</b> , that (I) (we) last saw the deceased alive on <b>1/30/85</b> , 19 <b>85</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.  |                         |   |  |   |   |
| 22b. SIGNATURE<br><b>D. Spierhas hover</b>  |                         | DEGREE<br><b>MD</b>   |  | 22c. DATE SIGNED<br><b>1/31/85</b>  |   |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)   |                         | 22e. ADDRESS  |  |   |   |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY) <b>BURIAL</b>  |                         | 23b. DATE<br><b>2/5/85</b>  |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>DuANEY VALLEY</b>  |   |
| 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>COCKEYSVILLE</b>   |                         | 24. FUNERAL DIRECTOR<br>NAME <b>CHATMAN HARRIS</b> ADDRESS <b>1701 McPherson</b>  |  |   |   |
| 25a. DATE REC'D. BY REGISTRAR   |                         | 25b. REGISTRAR'S SIGNATURE<br><b>Gelia Kudson-Randall</b>   |  |   |   |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use on the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours of death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified as soon as possible.





STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 5 0 1 6 9 3

FOR  
1- STATE  
REGISTRAR

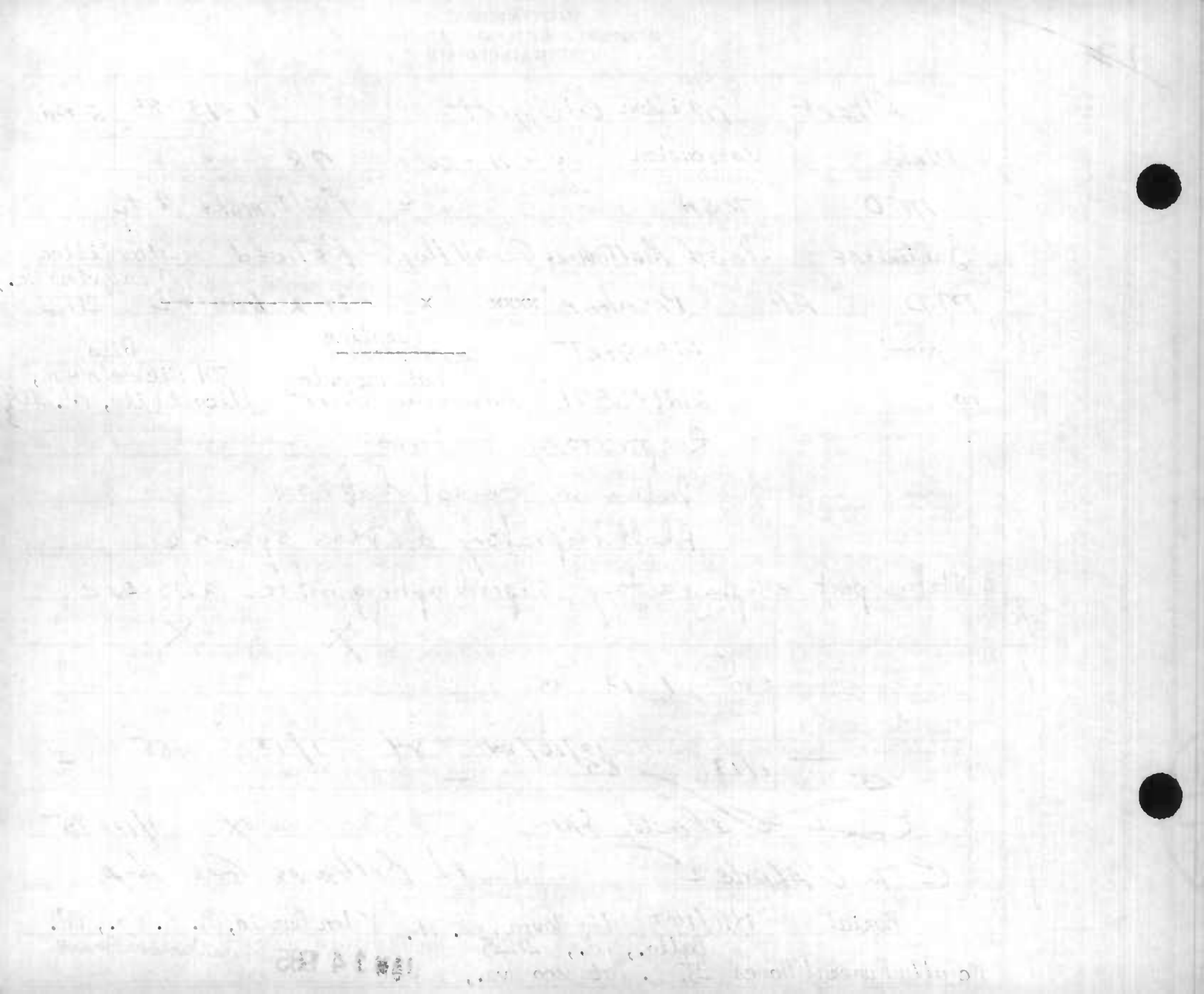
REG. NO.

|  |  |  |   |   |   |  |   |   |  |  |
|--|--|--|---|---|---|--|---|---|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>Albert Milton Wengert</b>   |  |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR <b>1-13-85</b>                              |   |   | 2b. HOUR<br><b>2:40 AM</b>   |   |   |  |  |
| 3 SEX<br><b>Male</b>   |  | 4 RACE<br><b>Caucasian</b>   |   | 5. DATE OF BIRTH<br>MONTH DAY YEAR <b>8-11-06</b>   |   | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>78</b> YRS   |   | IF UNDER 1 YEAR<br>MONTHS DAYS HOURS MIN.   |  |  |
| 7. BIRTHPLACE<br>(STATE OR FOREIGN COUNTRY) <b>M.D.</b>  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>   |   | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> |   | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore City</b> MD.  |   |   |  |  |
| 10. CITY OR TOWN OF DEATH<br><b>Baltimore</b>  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>South Baltimore General Hosp.</b> |   |   |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Retired</b>  |   | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>Steamfitter</b>   |  |  |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE <b>M.D.</b>   |  |  | 13b. COUNTY <b>AA</b>   |   | 13c. CITY OR TOWN <b>PASADENA</b>   |  | 13d. INSIDE CITY LIMITS?<br><del>YES</del> NO <input checked="" type="checkbox"/> |   | 13e. STREET ADDRESS / ZIP CODE <b>950 Longview Dr.,<br/>-21-61880 RD 21122</b> |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Conrad WENGERT</b>  |  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Caroline Wengert Otts</b>   |   |   |  |   |   |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) <b>no</b>   |  |  | 16b. SOCIAL SECURITY NO.<br><b>212180571</b>                                    |   | 17. INFORMANT <b>Ruth McGarley</b> ADDRESS <b>9501 Michaels Way,<br/>Admission Sheet Ellicott City, Md. 21043</b> |  |   |   |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Respiratory failure</b><br>DUE TO, OR AS A CONSEQUENCE OF (b) <b>Pulmonary consolidation</b><br>DUE TO, OR AS A CONSEQUENCE OF (c) <b>Adult respiratory distress syndrome</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. |  |  |   |   |   |  |   |   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH                                   |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (c)<br><b>Status post esophagectomy: supradiaphragmatic abscess</b>   |  |  |   |   |   |  |   |   |  |  |
| 19a. DATE OF OPERATION   |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                                |   |   | 20a. AUTOPSY?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>   |   | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  |  | 21b. TIME OF INJURY<br>HOUR (A.M.) MONTH DAY YEAR<br><b>9:40 P.M. 1 13 1985</b> |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)                                    |  |   |   |  |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  |  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)          |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |   |   |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>12/16/84</b> , 19 <b>84</b> , to <b>1/13</b> , 19 <b>85</b> , that (I) (we) lost saw the deceased alive on <b>1/13</b> , 19 <b>85</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.   |  |  |   |   |   |  |   |   |  |  |
| 22b. SIGNATURE<br><b>C. D. Valadez Sr.</b>   |  |  | DEGREE  |   |   | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> |   | 22c. DATE SIGNED<br><b>1/13/85</b>  |  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>C. D. Valadez</b>  |  |  | 22e. ADDRESS<br><b>South Baltimore Gen. Hosp.</b>                               |   |   |  |   |   |  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY) <b>Burial</b>   |  |  | 23b. DATE<br><b>1/16/1985</b>   |   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Glen Haven Mem. Ph.</b>  |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Glen Burnie, A. A. Co., Md.</b>  |   |  |  |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>McCully Funeral Homes</b>   |  |  | ADDRESS<br><b>Baltimore, Md., 21225<br/>237 E. Patapsco Ave.,</b>               |   | 25. DATE REC'D. BY REGISTRAR<br><b>JAN 14 1985</b>  |  | REGISTRAR'S SIGNATURE<br><b>John Davidson</b>                                     |   |  |  |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page number 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.



STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 5 0 1 6 9 4

1. FOR  
STATE  
REGISTRAR

REG. NO.

|   |  |   |  |   |   |   |  |  |  |
|---|--|---|--|---|---|---|--|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>Elsie Werner</b>   |  |   |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>1 20 85</b>   |   |   |  | 2b. HOUR<br><b>3<sup>05</sup> P.M.</b>   |  |
| 3. SEX<br><b>Female</b>   |  | 4. RACE<br><b>Caucasian</b>   |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>11 14 1897</b>   |   | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>88</b>  |  | 7. IF UNDER 1 YEAR<br>MONTHS DAYS  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Czechoslovakia</b>  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>yes - U.S.A.</b>   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Balto. City</b> MD.                                  |  |  |  |
| 10. CITY OR TOWN OF DEATH<br><b>Balto. City</b>   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Levindale Nsg. Home</b> |  |   |   | 12a. USUAL RESIDENCE (TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>HOUSEWIFE</b>                |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>AT HOME</b>  |  |
| 13a. STATE<br><b>MARYLAND</b>   |  | 13b. COUNTY   |  | 13c. CITY OR TOWN<br><b>BALTIMORE</b>   |   | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 13e. STREET ADDRESS<br><b>APT. 3C<br/>6001 PARK HTS. AVE. 21215</b>  |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>UNKNOWN</b>  |  |   |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>UNKNOWN</b>   |   |   |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) <b>NO</b>  |  |   |  | 16b. SOCIAL SECURITY NO<br><b>218-12-4506</b>   |   | 17. INFORMANT<br><b>WILLIAM J. DENTON</b><br>5736 GREENSPRING AVE. BALTO. MD 21209              |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>CARDIAC ARREST</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>A SCVD.</b><br>DUE TO, OR AS A CONSEQUENCE OF (c)          |  |   |  |   |   |   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH   |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <b>NO</b>  |  |   |  |   |   |   |  |  |  |
| 19a. DATE OF OPERATION  |  |   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                       |   |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>                       |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  |   | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>      |   |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)                  |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>   |  |   | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) |   |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>12-10</b> 19 <b>84</b> to <b>1-20</b> 19 <b>85</b> , that (I) (we) last saw the deceased alive on <b>1-20</b> 19 <b>85</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |  |   |  |   |   |   |  |  |  |
| 22b. SIGNATURE<br><b>B. ZAWWIN</b>  |  |   |  |   |   | DEGREE<br><b>MD</b>   |  | 22c. DATE SIGNED<br><b>1-20-85</b>   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>B. ZAWWIN</b>   |  |   |  |   |   | 22e. ADDRESS<br><b>Levindale Geriatric Ctr BALTO 21215</b>                                      |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY) <b>BURIAL</b>  |  |   | 23b. DATE<br><b>JAN. 23, 1985</b>                                      |   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>CHIZUK AMUNO</b> |   | 23d. LOCATION<br><b>BALTIMORE</b> COUNTY <b>MARYLAND</b> |  |  |
| 24. FUNERAL DIRECTOR<br>NAME <b>SOL LEVINSON &amp; BROS., INC.</b><br>ADDRESS <b>6010 REISTERSTOWN RD. BALTO., MD 21215</b>   |  |   |  |   |   | 25a. DATE REC'D BY REGISTRAR <b>JAN 24 1985</b>   |  |  |  |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbonpapers, Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

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1992

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 5 0 1 6 9 5

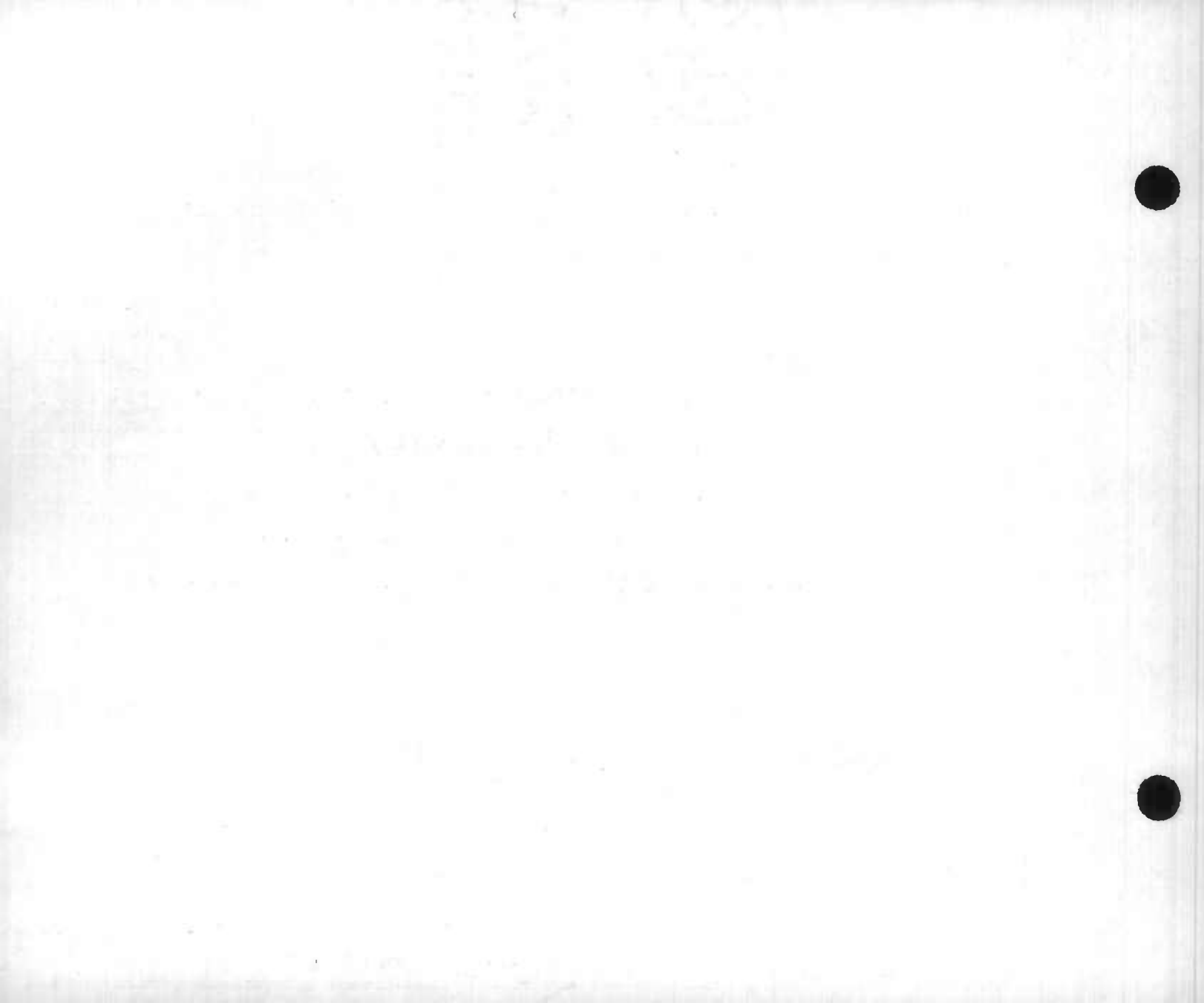
FOR  
1- STATE  
REGISTRAR

REG. NO.

|   |  |   |  |   |  |   |  |  |   |   |  |
|---|--|---|--|---|--|---|--|--|---|---|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>BEVERLY J. West</b>  |  |   | 2a. DATE OF DEATH<br>MONTH <b>1</b> DAY <b>15</b> YEAR <b>85</b> |   |  | 2b. HOUR<br><b>7:55P</b> M  |  |  |   |   |  |
| 3. SEX<br><b>Female</b>   |  | 4. RACE<br><b>Black</b>   |  | 5. DATE OF BIRTH<br>MONTH <b>6</b> DAY <b>9</b> YEAR <b>35</b>  |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>49</b> YRS.   |  | 7. IF UNDER 1 YEAR<br>MONTHS <b></b> DAYS <b></b>  |   | 8. IF UNDER 24 HRS.<br>HOURS <b></b> MIN. <b></b>   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Maryland</b>  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore City, MD.</b>                              |  |  |   |   |  |
| 10. CITY OR TOWN OF DEATH<br><b>Baltimore</b>   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Good Samaritan Hospital</b> |  |   |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)                                |  |  | 12b. KIND OF BUSINESS OR INDUSTRY   |   |  |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)   |  |   |  |   |  |   |  |  |   |   |  |
| 13a. STATE<br><b>Maryland</b>   |  | 13b. COUNTY<br><b>Baltimore</b>   |  | 13c. CITY OR TOWN<br><b>Baltimore</b>   |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 13e. STREET ADDRESS / ZIP CODE<br><b>941 Montpelier St. 21218</b>  |   |   |  |
| 14. FATHER'S NAME<br>FIRST <b>Alfred</b> MIDDLE <b>C.</b> LAST <b>West</b>  |  |   |  | 15. MOTHER'S MAIDEN NAME<br>FIRST <b>Ethel</b> MIDDLE <b></b> LAST <b>Crowdy</b>  |  |   |  |  |   |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) <b>NO</b>  |  |   |  | 16b. SOCIAL SECURITY NO.<br><b>216-32-3430</b>  |  | 17. INFORMANT<br>ADDRESS <b>Beatrice E. Christian 3407 Ellamont Rd</b>                          |  |  |   |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>CARDIOPULMONARY ARREST</b>  |  |   |  |   |  |   |  |  |   | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH   |  |
| DUE TO, OR AS A CONSEQUENCE OF<br>(b) <b>Ventricular Arrhythmias</b>  |  |   |  |   |  |   |  |  |   |   |  |
| DUE TO, OR AS A CONSEQUENCE OF<br>(c) <b>MYOCARDIAL ISCHEMIA.</b>   |  |   |  |   |  |   |  |  |   |   |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)<br><b>HYPER TENSION, DIABETES MELLITUS</b>  |  |   |  |   |  |   |  |  |   |   |  |
| 19a. DATE OF OPERATION  |  |   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  |   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>  |   | 20b. IF YES, WERE FINDINGS USED<br>IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  |   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>   |  |   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)   |   |   |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK  |  |   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  |   |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE  |   |   |  |
| 22a. I certify that (a) (this hospital) attended the deceased from <b>1/10</b> , 19 <b>85</b> , to <b>1/15</b> , 19 <b>85</b> , that (b) (we) last saw the deceased alive on <b>1/15</b> , 19 <b>85</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (If I (we) did not view the body after death, so state.) |  |   |  |   |  |   |  |  |   |   |  |
| 22b. SIGNATURE<br><b>R. M. Hines</b>  |  |   |  | DEGREE <b>M.D., Ph.D.</b>   |  |   |  | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> |   | 22c. DATE SIGNED<br><b>1/15/85</b>  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>R. M. HINES</b>   |  |   |  | 22e. ADDRESS<br><b>Johns Hopkins Hospital<br/>BALTIMORE MD. 21205</b>   |  |   |  |  |   |   |  |
| 23a. BURIAL, CREMATION, REMOVAL<br><b>BURIAL</b>  |  |   |  | 23b. DATE<br><b>1/21/85</b>   |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Cedar Hill Cemetery</b>                                |  |  | 23d. LOCATION<br>CITY OR TOWN <b>Arundel, Co.</b> COUNTY <b>Md.</b> STATE |   |  |
| 24. FUNERAL DIRECTOR<br>NAME <b>Wm C March F/H Inc.</b> ADDRESS <b>1101 E North Avenue</b>  |  |   |  |   |  | 25a. DATE REC'D BY REGISTRAR<br><b>JAN 18 1985</b>  |  | 25b. REGISTRAR'S SIGNATURE<br><b>[Signature]</b>   |   |   |  |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.  
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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DHMH - 16 50M 4/83  
(VRA 15, 4)

## MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH  |  |   |  | 8 5 0 1 6 9 6   |  |   |  |
|---|--|---|--|---|--|---|--|
| 1- FOR STATE REGISTRAR  |  |   |  | REG. NO.  |  |   |  |
| 1 DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST<br>GEORGE C. WEST   |  |   |  | 2a. DATE OF DEATH MONTH DAY YEAR<br>11/5/85   |  | 2b. HOUR<br>12:05A-M  |  |
| 3. SEX<br>MALE  |  | 4 RACE<br>BLK   |  | 5. DATE OF BIRTH MONTH DAY YEAR<br>5 3 1919   |  | 6. AGE (IN YEARS LAST BIRTHDAY) MONTHS DAYS HOURS MIN.<br>65 YRS.   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Wash. D.C.   |  | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.A.  |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>City MD.  |  |
| 10. CITY OR TOWN OF DEATH<br>Baltimore  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>LUTHERAN HOSPITAL |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Truck Driver   |  | 12b. KIND OF BUSINESS OR INDUSTRY<br>PAINT  |  |
| 13a. STATE<br>Md.   |  |   |  | 13b. COUNTY<br>BALTO.   |  | 13c. CITY OR TOWN<br>Baltimore  |  |
| 14. FATHER'S NAME FIRST MIDDLE LAST<br>Thomas West  |  |   |  | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST<br>Bessie E. Perry   |  |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)<br>No   |  | 16b. SOCIAL SECURITY NO.  |  | 17. INFORMANT ADDRESS<br>George C. West, Jr. 3333 Ripple Rd   |  |   |  |
| 18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) MYO CARDIAL INFARCTION<br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) VALVULAR HEART DISEASE<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c)  |  |   |  |   |  |   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a  |  |   |  |   |  |   |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>  |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR<br>P.M. 19   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)  |  |   |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK   |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE  |  |   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from 12/25, 1984 to 1/15, 1985, that (I) (we) lost saw the deceased alive on 1/15, 1985, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |  |   |  |   |  |   |  |
| 22b. SIGNATURE<br>L. C. C. C.   |  |   |  | DEGREE  |  | 22c. DATE SIGNED<br>11/5/85   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>LEONINA L. CUETO   |  |   |  | 22e. ADDRESS<br>LUTHERAN HOSPITAL   |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br>Burial   |  | 23b. DATE<br>1-18-85  |  | 23c. NAME OF CEMETERY OR CREMATORY<br>Lincoln Mem.  |  | 23d. LOCATION CITY OR TOWN COUNTY STATE<br>Suitland Md.   |  |
| 24. FUNERAL DIRECTOR NAME<br>JAMES A. BRADY   |  |   |  | ADDRESS<br>1701 Leaden  |  | 25a. DATE REC'D. BY REGISTRAR<br>JAN 16 1985  |  |
|   |  |   |  | 25b. REGISTRAR'S SIGNATURE<br>[Signature]   |  |   |  |

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Section

2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20 21 22 23 24 25 26 27 28 29 30 31 32 33 34 35 36 37 38 39 40 41 42 43 44 45 46 47 48 49 50 51 52 53 54 55 56 57 58 59 60 61 62 63 64 65 66 67 68 69 70 71 72 73 74 75 76 77 78 79 80 81 82 83 84 85 86 87 88 89 90 91 92 93 94 95 96 97 98 99 100

11/10/11



200-101-011

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 4 should be detached for use as the burial-transit permit. Then please remove carbon-copies, Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 5 0 1 6 9 7

FOR  
1. STATE  
REGISTRAR

REG. NO.

|   |  |  |  |   |   |  |   |   |   |  |
|---|--|--|--|---|---|--|---|---|---|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>CHARLES William WETZELBERGER Sr.   |  |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br>Jan 22 1985                     |   |   | 2b. HOUR<br>1 34 PM  |   |   |   |  |
| 3. SEX<br>Male  |  | 4. RACE<br>White   |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>06/23/03  |   | 6. AGE (IN YEARS LAST BIRTHDAY)<br>81 YRS.   |   | 7. IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS.<br>HOURS MIN.   |   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Maryland   |  | 7b. CITIZEN OF WHAT COUNTRY?<br>USA  |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>BALTIMORE CITY MD.   |   |   |   |  |
| 10. CITY OR TOWN OF DEATH<br>BALTIMORE  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>UNION MEMORIAL HOSPITAL |  |   |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Mechanic   |   | 12b. KIND OF BUSINESS OR INDUSTRY<br>Oil Burner   |   |  |
| 13a. STATE<br>Md  |  |  | 13b. COUNTY<br>Baltimore   |   | 13c. CITY OR TOWN<br>Baltimore  |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |   | 13e. STREET ADDRESS / ZIP CODE<br>4234 Falls Road 21211 |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>Frederick Charles Wetzelsberger   |  |  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Sarah Mac Dougall  |   |  |   |   |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)<br>No  |  |  | 16b. SOCIAL SECURITY NO.<br>216 01 1070                                |   | 17. INFORMANT<br>ADDRESS<br>Mary Ethel Wetzelsberger same                         |  |   |   |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Cardiac Arrest</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____<br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><u>minutes</u> |  |  |  |   |   |  |   |   |   |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: _____  |  |  |  |   |   |  |   |   |   |  |
| 19a. DATE OF OPERATION  |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                       |   |   | 20a. AUTOPSY?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>   |   | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |   |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19             |   | 21c. HOW INJURY OCCURRED<br>(ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) |  |   |   |   |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK  |  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                 |  |   |   |   |  |
| 22a. I certify that (a) (this hospital) attended the deceased from <u>1981</u> , 19 <u>85</u> , to <u>1/22</u> , 19 <u>85</u> , that (b) (we) lost <u>know the deceased alive on 1/21/85</u> and that (c) (my) (our) opinion death occurred on the date and hour and from the causes stated above.  |  |  |  |   |   |  |   |   |   |  |
| 22b. SIGNATURE<br><u>Richard L Diamond</u>  |  |  | DEGREE<br>MD   |   |   | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |   | 22c. DATE SIGNED<br>1/22/85   |   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>RICHARD L DIAMOND  |  |  | 22e. ADDRESS<br>3547 Chestnut Ave Balt 21211                           |   |   |  |   |   |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br>Burial   |  |  | 23b. DATE<br>01/26/85  |   | 23c. NAME OF CEMETERY OR CREMATORY<br>New Cathedral Cemetery                      |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Baltimore, Maryland                               |   |   |  |
| 24. FUNERAL DIRECTOR<br>NAME<br>Burgee-Henss Funeral Home   |  |  |  |   | 25a. DATE REC'D. BY REGISTRAR 1985  |  |   |   |   |  |
| ADDRESS<br>3631 Falls Road 21211  |  |  |  |   | 25b. REGISTRAR'S SIGNATURE  |  |   |   |   |  |

BP.



STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 5 0 1 6 9 8

1- FOR  
STATE  
REGISTRAR

REG. NO.

|  |  |   |   |  |  |   |  |
|--|--|---|---|--|--|---|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>FIRST MIDDLE LAST<br><u>WILLIAM</u> <u>WHEATCEY</u> |  |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><u>1-24-85</u> |  |  | 2b. HOUR<br><u>11:30 A.M.</u>   |  |
| 3. SEX<br><u>MALE</u>  |  | 4. RACE<br><u>WHITE</u>   |   | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><u>01 27 91</u>  |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><u>94</u> YRS.                               |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><u>UNKNOWN MD.</u>                            |  | 7b. CITIZEN OF WHAT COUNTRY?<br><u>USA</u>  |   | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 7. BALTIMORE CITY OR COUNTY OF DEATH<br><u>BALTIMORE CITY</u> MD.               |  |
| 10. CITY OR TOWN OF DEATH<br><u>BALTIMORE</u>  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><u>LUTHERAN HOSPITAL</u> |   |  |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><u>NONE</u> |  |
| 12b. KIND OF BUSINESS OR INDUSTRY<br><u>STEEL</u>  |  | 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE<br><u>Md.</u>              |   | 13b. COUNTY<br><u>---</u>  |  | 13c. CITY OR TOWN<br><u>BALTIMORE</u>   |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><u>JAMES W. WHEATCEY</u>                         |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><u>MARY SCHAFER</u>  |   | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>  |  | 13b. STREET ADDRESS<br><u>1213 LIGHT ST</u><br><u>FEDERAL HILL NH. 21230</u>    |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><u>YES</u>         |  | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br><u>WWI</u>   |   | 17. INFORMANT<br><u>WILLIAM H. WHEATCEY</u>  |  | ADDRESS<br><u>106 FORWARD LN</u>  |  |

## 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) Respiratory failure

DUE TO, OR AS A CONSEQUENCE OF

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.

(b) pneumonia

DUE TO, OR AS A CONSEQUENCE OF

(c) \_\_\_\_\_

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

## PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)

|   |  |  |  |  |  |  |  |
|---|--|--|--|--|--|--|--|
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                         |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><u>P.M.</u> <u>19</u> |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)   |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE  |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>12-16-</u> 19 <u>84</u> , to <u>1-24</u> 19 <u>85</u> , that (I) (we) lost saw the deceased alive on <u>1-24-</u> 19 <u>85</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |  |  |  |  |  |  |  |
| 22b. SIGNATURE<br><u>M. Mathew</u>  |  |  |  | DEGREE<br>ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> |  | 22c. DATE SIGNED<br><u>1-24-85</u>   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><u>A. Mathew</u>   |  |  |  | 22e. ADDRESS<br><u>Lutheran Hospital 730 Ashbmoor St Baltimore</u>   |  |  |  |

MEDICAL CERTIFICATION

29

|  |  |                             |  |   |  |  |  |
|--|--|-----------------------------|--|---|--|--|--|
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><u>CREMATION</u> |  | 23b. DATE<br><u>1/25/85</u> |  | 23c. NAME OF CEMETERY OR CREMATORY<br><u>SECURITY PROCESS</u> |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><u>BALTO MD.</u> |  |
| 24. FUNERAL DIRECTOR<br>NAME<br><u>CONNELLI F.H.</u>             |  |                             |  | 25a. DATE REC'D. BY REGISTRAR<br><u>JAN 30 1985</u>           |  | 25. REGISTRAR'S SIGNATURE<br><u>La Davidson-Randall</u>        |  |

BP \_\_\_\_\_

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.



WAX  
20% COTTON

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely legible by the funeral director, page 3 should be detached for use at the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal (IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once).

BP

DHMH - 16 50M 4/83  
(VRA 15, 4)

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH  |  |  |  | REG. NO. 85 01699   |  |  |  |  |  |
|---|--|--|--|---|--|--|--|--|--|
| 1. FOR STATE REGISTRAR  |  |  |  | 2a. DATE OF DEATH MONTH DAY YEAR 1 14 85  |  |  |  | 2b. HOUR 2:55 PM   |  |
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST CLINTON HERBERT WHEELER JR.  |  |  |  | 3. SEX M  |  |  |  | 4. RACE W  |  |
| 5. DATE OF BIRTH MONTH DAY YEAR 11 08 11  |  |  |  | 6. AGE (IN YEARS LAST BIRTHDAY) 73  |  |  |  | 7. IF UNDER 1 YEAR IF UNDER 24 HRS. MONTHS DAYS HOURS MIN.   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MARYLAND  |  |  |  | 7b. CITIZEN OF WHAT COUNTRY? U.S.A.   |  |  |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  |
| 9. BALTIMORE CITY OR COUNTY OF DEATH Balt. City MD.   |  |  |  | 10. CITY OR TOWN OF DEATH Balt.   |  |  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) South Baltimore General Hosp                      |  |
| 12a. USUAL OCCUPATION (TYPE OR WORK FOR MOST OF WORKING LIFE) CLERK   |  |  |  | 12b. KIND OF BUSINESS OR INDUSTRY RAILROAD  |  |  |  | 13a. STATE MARYLAND  |  |
| 13b. COUNTY ---   |  |  |  | 13c. CITY OR TOWN BALTIMORE   |  |  |  | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>   |  |
| 13e. STREET ADDRESS / ZIP CODE 1139 W. HAMBURG ST., 21230   |  |  |  | 14. FATHER'S NAME FIRST MIDDLE LAST CLINTON HERBERT WHEELER SR.   |  |  |  | 15. MOTHER'S MAIDEN NAME MIDDLE LAST AMY MILLSTONE   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO  |  |  |  | 16b. SOCIAL SECURITY NO. 215-07-3943  |  |  |  | 17. INFORMANT ADDRESS ANNA F. WHEELER 1139 W. HAMBURG ST. 21230  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) Respiratory Failure (Respiratory)<br>DUE TO, OR AS A CONSEQUENCE OF (b) Squamous Cell Carcinoma of Lungs<br>DUE TO, OR AS A CONSEQUENCE OF (c) |  |  |  |   |  |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH   |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)   |  |  |  |   |  |  |  |  |  |
| 19a. DATE OF OPERATION  |  |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  |  |  | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>   |  |
| 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>   |  |  |  | 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |  |  |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19   |  |
| 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)   |  |  |  | 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK  |  |  |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  |
| 21f. LOCATION STREET CITY OR TOWN COUNTY STATE  |  |  |  | 21g. I certify that (I) (this hospital) attended the deceased from JAN 13, 1985 to Jan 14, 1985 that (I) (we) last saw the deceased alive on Jan 14, 1985, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |  |  |  | 22a. SIGNATURE Paul Wandy, M.D. DEGREE   |  |
| 22b. PHYSICIAN'S NAME (TYPE OR PRINT) Paul Warshawsky / Dr Ramos  |  |  |  | 22c. DATE SIGNED 1/14/85  |  |  |  | 22d. ADDRESS 347 P 200 South Baltimore General Hospital  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL  |  |  |  | 23b. DATE 01-17-85  |  |  |  | 23c. NAME OF CEMETERY OR CREMATORY LORRAINE PARK   |  |
| 23d. LOCATION CITY OR TOWN COUNTY STATE WOODLAWN BALTIMORE MARYLAND   |  |  |  | 24. FUNERAL DIRECTOR NAME HUBBARD FUNERAL HOME, INC. 4107 WILKENS AVE. ADDRESS 21229  |  |  |  | 25a. DATE REC'D. BY REGISTRAR 25b. REGISTRAR'S SIGNATURE JAN 16 1985   |  |





20% COLLECT

TO HOSPITAL OR ATTENDING PHYSICIAN: The following death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8501700

1- STATE  
REGISTRAR

REG. NO.

|  |  |   |   |   |  |   |  |  |  |
|--|--|---|---|---|--|---|--|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>FIRST MIDDLE LAST<br>Mary Louisa White  |  |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br>January 24, 1985 |   |  | 2b. HOUR<br>01:13 PM  |  |  |  |
| 3. SEX<br>Female   |  | 4. RACE<br>White  |   | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>June 21, 1897   |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br>87 Yrs.  |  | 7. IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS.<br>HOURS MIN.  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Balto., Md.   |  | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.A.  |   | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Baltimore City MD.                                      |  |  |  |
| 10. CITY OR TOWN OF DEATH<br>Baltimore   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>The Johns Hopkins Hospital |   |   |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>HOMEMAKER                   |  | 12b. KIND OF BUSINESS OR INDUSTRY  |  |
| 13a. STATE<br>Maryland   |  | 13b. COUNTY   |   | 13c. CITY OR TOWN<br>Baltimore  |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 13e. STREET ADDRESS / ZIP CODE<br>6550 St. Helena Ave. 21222   |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>Aaron Grammer  |  |   |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Mary Gompf   |  |   |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br>No   |  | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br>216.76.0741  |   | 17. INFORMANT<br>ADDRESS<br>Juanita D. Saltz (Same as 13e)  |  |   |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Respiratory Failure</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <u>Myasthenia Gravis</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. |  |   |   |   |  |   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><u>Days</u><br><u>Months</u>   |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:<br><u>Chronic Obstructive Pulmonary Disease; Pneumonia</u>  |  |   |   |   |  |   |  |  |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |   |   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>            |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)   |  |   |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |   |  |  |  |
| 22. I certify that (I) (this hospital) attended the deceased from <u>1/22</u> , 19 <u>85</u> , to <u>1/24</u> , 19 <u>85</u> , that (I) (we) lost saw the deceased live on <u>1/24</u> , 19 <u>85</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.               |  |   |   |   |  |   |  |  |  |
| 22b. SIGNATURE<br><u>Jeanne C. Rubenstone MD</u> DEGREE<br>ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>  |  |   |   |   |  | 22c. DATE SIGNED<br><u>1/24/85</u>  |  |  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><u>Jeanne C. Rubenstone MD</u>  |  |   |   | 22e. ADDRESS<br><u>Johns Hopkins Hospital</u>   |  |   |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br>Burial   |  | 23b. DATE<br>1/26/1985  |   | 23c. NAME OF CEMETERY OR CREMATORY<br>Baltimore Cemetery  |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Baltimore Maryland                                |  |  |  |
| 24. FUNERAL DIRECTOR<br>Walter Brooks Bradley Inc., Dundalk, Md. 21222   |  |   |   | 25a. DATE REC'D. BY REGISTRAR<br>JAN 29 1985  |  | 25b. REGISTRAR'S SIGNATURE<br><u>Davidson-Randall</u>   |  |  |  |

BP

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 1 and 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

85 01701

FOR  
STATE  
REGISTRAR

REG. NO.

|   |  |  |   |   |                                |   |   |  |  |
|---|--|--|---|---|--------------------------------|---|---|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>VIRGINIA B. WHITE  |  |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br>11/19/85                   |   |                                | 2b. HOUR<br>10 A M  |   |  |  |
| 3. SEX<br>Female  |  | 4. RACE<br>White   |   | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>6 6 05  |                                | 6. AGE (IN YEARS LAST BIRTHDAY)<br>79 YRS   |   | 7. IF UNDER 1 YEAR<br>MONTHS DAYS HOURS MIN.   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Maryland   |  | 7b. CITIZEN OF WHAT COUNTRY?<br>USA  |   | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |                                | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Baltimore City MD.  |   |  |  |
| 10. CITY OR TOWN OF DEATH<br>Baltimore  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>Union Memorial Hospital 21218 |   |   |                                | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Retired   |   | 12b. KIND OF BUSINESS OR INDUSTRY  |  |
| 13a. STATE<br>Maryland  |  |  | 13b. COUNTY<br>--   |   | 13c. CITY OR TOWN<br>Baltimore |   | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>George J. Bond  |  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Laura Whitehouse |   |                                | 13e. STREET ADDRESS / ZIP CODE<br>927 W. 33rd Street 21211  |   |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br>No  |  | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br>--  |   | 17. INFORMANT<br>ADDRESS<br>Jane Appleby 927 W. 33rd Street 21211   |                                |   |   |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Massive CVA - hemorrhagic</u><br>DUE TO, OR AS A CONSEQUENCE OF (b) <u>c brainstem herniation</u><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>DUE TO, OR AS A CONSEQUENCE OF (c)<br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br>36 hrs. |  |  |   |   |                                |   |   |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)<br><u>None</u>  |  |  |   |   |                                |   |   |  |  |
| 19a. DATE OF OPERATION<br><u>---</u>  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED<br><u>---</u>   |   |   |                                | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |   | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19   |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)   |                                |   |   |  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |                                |   |   |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>11/17</u> , 19 <u>85</u> , to <u>11/19</u> , 19 <u>85</u> , that (I) (we) lost<br>saw the deceased <u>die</u> on <u>11/19</u> , 19 <u>85</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated<br>above, (I) (we) (did) (did not) view the body after death.  |  |  |   |   |                                |   |   |  |  |
| 22b. SIGNATURE<br><u>M. Keith Rawlings</u><br>22e. PHYSICIAN'S NAME (TYPE OR PRINT)<br>Rawlings   |  |  |   |   |                                | DEGREE<br>ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> |   | 22c. DATE SIGNED<br>1/19/85  |  |
| 22f. ADDRESS<br>Union Memorial Hospital   |  |  |   |   |                                |   |   |  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br>Burial  |  | 23b. DATE<br>1/22/85   |   | 23c. NAME OF CEMETERY OR CREMATORY<br>Lorraine Park Cem.  |                                | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Baltimore Maryland  |   |  |  |
| 24. FUNERAL DIRECTOR<br>NAME<br>A. Alan Seitzer Jr. 3818 Roland Ave. 21211  |  |  |   |   |                                | DATE REC'D. BY REGISTRAR<br>JAN 24 1985<br>REGISTRAR'S SIGNATURE<br>John Davidson   |   |  |  |

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Handwritten text at the bottom left, possibly a signature or date.

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE 8 5 0 1 7 0 2  
CERTIFICATE OF DEATH

1- FOR  
STATE  
REGISTRAR

REG. NO.

|   |  |  |  |  |  |
|---|--|--|--|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>FRANK S. WHITMORE  |  |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br>1 17 85<br>10:07 AM                   |  |  |
| 3 SEX<br>Male   | 4 RACE<br>White  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>11 21 17   | 6 AGE (IN YEARS LAST BIRTHDAY)<br>67   |  |  |
| 7a BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Washington, D.C.  | 7b CITIZEN OF WHAT COUNTRY?<br>U.S.  | 8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> | 9 BALTIMORE CITY OR COUNTY OF DEATH<br>Baltimore MD                          |  |  |
| 10 CITY OR TOWN OF DEATH<br>Baltimore   | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>Keswick |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Director |  | 12b. KIND OF BUSINESS OR INDUSTRY<br>Lung Assn.                    |
| 13a. STATE<br>Md.   |  | 13b. COUNTY<br>Balto.  | 13c. STREET ADDRESS / ZIP CODE<br>3633 Greenmount Ave. 21218                 |  | 21218  |
| 14 FATHER'S NAME<br>FIRST MIDDLE LAST<br>Clarence W. Whitmore   |  | 15 MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Ethel Hanna McClary  |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br>Yes   |  | 16b. SOCIAL SECURITY NO.<br>213-18-9960  |  | 17 INFORMANT ADDRESS<br>2913 Bradford Ln.<br>Ms. Susan W. Stevenson Bowie, Md. |  |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Alzheimers Disease</u><br>DUE TO, OR AS A CONSEQUENCE OF (b) _____<br>DUE TO, OR AS A CONSEQUENCE OF (c) _____<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost         |  |  |  |  | APPROXIMATE INTERVAL BETWEEN DEATH AND DEATH CERTIFICATE<br>10 yrs |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a:   |  |  |  |  |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>      |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                              |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>17 Jan</u> 19 <u>85</u> , to <u>17 Jan</u> 19 <u>85</u> , that (I) (we) last saw the deceased alive on <u>17 Jan</u> 19 <u>85</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (If we did not view the body after death.) |  |  |  |  |  |
| 22b. SIGNATURE<br>Hubrey D. Richardson M.D.   |  | DEGREE   |  | 22c. DATE SIGNED<br>17 Jan 1985  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>Hubrey D. Richardson M.D.  |  | 22e. ADDRESS<br>700 W. 40th St. Baltimore Md 21211   |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br>Removal   |  | 23b. DATE<br>1/18/85   |  | 23c. NAME OF CEMETERY OR CREMATORY   |  |
| 24 FUNERAL DIRECTOR<br>NAME<br>Anatomy Board  |  | ADDRESS<br>Balto., Md.   |  | 25a. DATE REC'D. BY REGISTRAR<br>JAN 23 1985                                   |  |
|   |  |  |  | 25b. REGISTRAR'S SIGNATURE<br>Davidson-Randall                                 |  |

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200

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MEDICAL CERTIFICATION

9

9

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

85 01703

FOR  
STATE  
REGISTRAR

REG. NO.

|  |  |   |  |   |  |  |  |
|--|--|---|--|---|--|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>Mabel E. Eva Whitmore |  |   | 2. DATE OF DEATH<br>MONTH DAY YEAR<br>1/7/85 |   |  | 2b. HOUR<br>10:00 M  |  |
| 3. SEX<br>Female   |  | 4. RACE<br>White  |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>8 14 14   |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br>70 YES                  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)                    |  | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.  |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Baltimore City MD. |  |
| 10. CITY OR TOWN OF DEATH<br>City                            |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>Luthersburg Hospital |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>None  |  | 12b. KIND OF BUSINESS OR INDUSTRY<br>None                  |  |
| 13a. STATE<br>Md.  |  | 13b. COUNTY   |  | 13c. CITY OR TOWN<br>City   |  | 13d. STREET ADDRESS / ZIP CODE<br>2801 Rayner Ave. 21228   |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>George R Whitmore  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Minnie Miller  |  | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)  |  |  |  |
| 16b. SOCIAL SECURITY NO.<br>217019608                        |  | 17. INFORMANT<br>Doris J. Rose  |  | ADDRESS<br>Kingwood Texas 827 C Timberline  |  |  |  |

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).  
PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) CARDIAC ARREST

DUE TO, OR AS A CONSEQUENCE OF

(b) PNEUMONIA

DUE TO, OR AS A CONSEQUENCE OF

(c)

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)

COPD

|   |  |  |  |  |  |  |  |
|---|--|--|--|--|--|--|--|
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                       |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>  |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19             |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)  |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE  |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from 12/7/84, 1984, to 1/7, 1985, that (I) (we) lost<br>saw the deceased alive on 1/6/85, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated<br>above, (I) (we) (did) (did not) view the body after death. |  |  |  |  |  |  |  |
| 22b. SIGNATURE<br>Edward W. Schaefer Jr.  |  | DEGREE<br>M.D.   |  | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |  | 22c. DATE SIGNED<br>1/7/85   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>EDWARD W. SCHAEFER JR. M.D.  |  | 22e. ADDRESS<br>730 ASHBURTON ST. BALT. MD. 21216                      |  |  |  |  |  |

|   |  |                     |  |  |  |   |  |
|---|--|---------------------|--|--|--|---|--|
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br>Cremation |  | 23b. DATE<br>1-8-85 |  | 23c. NAME OF CEMETERY OR CREMATORY<br>Security Process |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Baltimore Md. |  |
| 24. FUNERAL DIRECTOR<br>MacNabb Funeral Home              |  |                     |  | ADDRESS<br>Catonsville Md                              |  | 25a. DATE REC'D. BY REGISTRAR<br>JAN 9 1985                 |  |
| 25b. REGISTRAR'S SIGNATURE<br>John Davidson-Randall       |  |                     |  |  |  |   |  |



CHILLYMAN

20% COTTON



THE CHILLYMAN COMPANY, NEW YORK, N.Y.

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

85 01704

1- FOR  
STATE  
REGISTRAR

REG. NO.

|   |  |   |  |   |  |   |  |  |  |  |  |
|---|--|---|--|---|--|---|--|--|--|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>CLARISE MERRIE WIDEMAN   |  |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br>1-29-85 |   |  | 2b. HOUR<br>10 <sup>15</sup> AM   |  |  |  |  |  |
| 3. SEX<br>Female  |  | 4. RACE<br>Col. 2   |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>4-12-1913   |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br>71 YRS.                                    |  |  |  |  |  |
| 7a. BIRTHPLACE<br>(COUNTRY)<br>VA.  |  | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.A.  |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Baltimore City MD.                    |  |  |  |  |  |
| 10. CITY OR TOWN OF DEATH<br>Balto.   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>2326 Braddish Ave. |  |   |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING YRS.)<br>Homemaker |  | 12b. KIND OF BUSINESS OR INDUSTRY  |  |  |  |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>STATE<br>Maryland   |  |   |  | 13b. CITY OR TOWN<br>Balto.   |  | 13c. STREET ADDRESS / ZIP CODE<br>2326 Braddish Ave 21216                     |  |  |  |  |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>UNKNOWN   |  |   |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Johnnie Mae Powell   |  |   |  |  |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br>NO  |  |   |  | 16b. SOCIAL SECURITY NO.<br>217-03-4884   |  | 17. INFORMANT<br>ADDRESS<br>Mr. McKinley Wideman 2326 Braddish Ave 21216      |  |  |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) Metastatic Colon Cancer  |  |   |  |   |  |   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br>17 months  |  |  |  |
| DUE TO, OR AS A CONSEQUENCE OF<br>(b)   |  |   |  |   |  |   |  |  |  |  |  |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last   |  |   |  |   |  |   |  |  |  |  |  |
| DUE TO, OR AS A CONSEQUENCE OF<br>(c)   |  |   |  |   |  |   |  |  |  |  |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)  |  |   |  |   |  |   |  |  |  |  |  |
| 19a. DATE OF OPERATION  |  |   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  |   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>  |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  |   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |  |   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)   |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>   |  |   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  |   |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE  |  |  |  |
| 22a. I certify that (1) this hospital attended the deceased from July 1983, to Jan 29 1985, that (1) we last saw the deceased alive on Dec 14, 1984, and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (1) I (we) (did) (did not) view the body after death. |  |   |  |   |  |   |  |  |  |  |  |
| 22b. SIGNATURE<br>Charles Padgett   |  |   |  | DEGREE<br>MD  |  |   |  | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |  | 22c. DATE SIGNED<br>1/30/85  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>CHARLES PADGETT  |  |   |  | 22e. ADDRESS<br>5601 Loch Raven Blvd.   |  |   |  |  |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(BY)<br>Burial   |  |   |  | 23b. DATE<br>2-1-85   |  | 23c. NAME OF CEMETERY OR CREMATORY<br>Garrison Forest                         |  |  |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Lanham Owings Mills MD.  |  |
| 24. FUNERAL DIRECTOR<br>NAME<br>Joseph L. Russ  |  |   |  | ADDRESS<br>2222 W. North Ave.   |  |   |  | 25a. DATE REC'D. BY REGISTRAR<br>FEB 6 1985  |  |  |  |
|   |  |   |  | REGISTRAR'S SIGNATURE<br>John Davidson-Randall  |  |   |  |  |  |  |  |

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 24 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked as item 18 shows any injury, or other traumatic event, the medical examiner will be notified of this.

BP



STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH85 01705  
REG. NO.

|  |  |  |  |   |              |   |   |  |                      |   |  |
|--|--|--|--|---|--------------|---|---|--|----------------------|---|--|
| 1. FOR STATE REGISTRAR   |  | 1. DECEASED NAME<br>(TYPE OR PRINT)  |  | FIRST<br>Anna   | MIDDLE<br>P. | LAST<br>Wild  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br>1 6 85 |  | 2b. HOUR<br>11:20/PM |   |  |
| 3. SEX<br>FEMALE   |  | 4. RACE<br>WHITE   |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>9 26 1899   |              | 6. AGE (IN YEARS LAST BIRTHDAY)<br>85 YRS   |   | 7. IF UNDER 1 YEAR<br>MONTHS DAYS  |                      | 7b. IF UNDER 24 HRS<br>HOURS MIN.                 |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>MARYLAND  |  | 7b. CITIZEN OF WHAT COUNTRY?<br>USA  |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |              | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>BALTIMORE CITY MD.                                      |   |  |                      |   |  |
| 10. CITY OR TOWN OF DEATH<br>BALTIMORE CITY  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>Garden Village Nursing Home                       |  |   |              | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Housewife                   |   | 12b. KIND OF BUSINESS OR INDUSTRY<br>Homemaking  |                      |   |  |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE Maryland 13b. COUNTY Baltimore  |  |  |  | 13c. CITY OR TOWN   |              | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |   | 13e. STREET ADDRESS / ZIP CODE<br>3 E. Elm Avenue Balto. Md. 21206   |                      |   |  |
| 14. FATHER'S NAME<br>FIRST George MIDDLE W. LAST Whittle   |  |  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST Mary MIDDLE LAST Graham   |              |   |   |  |                      |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)   |  | 16b. SOCIAL SECURITY NO.<br>214-03-6529  |  | 17. INFORMANT<br>Christian Wild   |              |   |   | ADDRESS<br>7301 Mt. Vista Rd. 21087  |                      |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Acute Myocardial Infarction</u><br>DUE TO, OR AS A CONSEQUENCE OF (b) <u>Arteriosclerotic Cardiovascular Disease</u><br>DUE TO, OR AS A CONSEQUENCE OF (c) <u>years</u><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last |  |  |  |   |              |   |   |  |                      | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br>— |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)<br><u>Chronic Cholecystitis - Renal Failure</u>   |  |  |  |   |              |   |   |  |                      |   |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  |   |              | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>                       |   | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |                      |   |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)  |              |   |   |  |                      |   |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |              |   |   |  |                      |   |  |
| 22a. I certify that (I) (the hospital) attended the deceased from <u>10/29/84</u> to <u>11/6/85</u> , that (I) (we) last saw the deceased alive on <u>12/1/84</u> 19 <u>84</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did not) view the body after death.  |  |  |  |   |              |   |   |  |                      |   |  |
| 22b. SIGNATURE<br><u>Albert B. Bradley</u>   |  | DEGREE <u>MD</u><br>ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |  |   |              | 22c. DATE SIGNED<br><u>11/2/85</u>  |   |  |                      |   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>ALBERT B. BRADLEY, M.D.   |  |  |  | 22e. ADDRESS<br>4900 BELAIR ROAD BALTIMORE, MD. 21206   |              |   |   |  |                      |   |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br>Burial   |  | 23b. DATE<br>1-9-85  |  | 23c. NAME OF CEMETERY OR CREMATORY<br>Gardens of Faith  |              | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Baltimore, Maryland                               |   |  |                      |   |  |
| 24. FUNERAL DIRECTOR<br>NAME<br>Lassahn Funeral Home   |  | 25a. DATE REC'D. BY REGISTRAR<br>JAN 8 1985  |  | 25b. REGISTRAR'S SIGNATURE<br><u>Davidson-Randall</u>   |              |   |   |  |                      |   |  |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the Medical Examiner must be notified and a postmortem examination required.

BP

2

J. M. Williams • P. D. Stolar

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 5 0 1 7 0 6  
REG. NO.

FOR  
1- STATE  
REGISTRAR

|   |  |   |  |   |  |   |  |
|---|--|---|--|---|--|---|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)   |  | FIRST MIDDLE LAST<br>JOHN T. WILHELM, SR.   |  | 2a. DATE OF DEATH MONTH DAY YEAR<br>1-5-85  |  | 2b. HOUR<br>M   |  |
| 3. SEX<br>M   |  | 4. RACE<br>W  |  | 5. DATE OF BIRTH MONTH DAY YEAR<br>10-24-1928   |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br>56 YRS.                                    |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>MARYLAND   |  | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.A.  |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>BALTIMORE CITY - MD.                  |  |
| 10. CITY OR TOWN OF DEATH<br>BALTO.   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>FRANCIS SCOTT KEY HOSP.  |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Co ORDINATOR  |  | 12b. KIND OF BUSINESS OR INDUSTRY<br>AFL-CIO                                  |  |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE<br>MD  |  | 13b. CITY OR TOWN<br>BALTO.   |  | 13c. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  | 13d. STREET ADDRESS<br>7833 E. COLLINGHAM DR. 21222                           |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>CHARLES L. WILHELM  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>MARIE E. SHANEY  |  | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br>YES   |  | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br>KOREAN 214-24-3808 |  |
| 16c. INFORMANT<br>ADDRESS<br>Mrs. Henrietta C. Wilhelm - 7833 E. Collingham Dr. 21222   |  | 17. CAUSE OF DEATH: Enter only one cause per line for (a), (b), and (c).<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) acute myocardial infarction<br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) atherosclerosis<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c)<br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br>1 hr |  | PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:<br>19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                              |  |
| 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>   |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>  |  | 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)    |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19                    |  |
| 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |  | 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                             |  |
| 22a. I certify that (I) (this hospital) attended the deceased from<br>saw the deceased alive on Sept 15, 1984, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated<br>above (I) (we) (did) (did not) view the body after death. |  | 22b. SIGNATURE<br>F. E. Chatham MD  |  | 22c. DATE SIGNED  |  | 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>F. E. Chatham                        |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br>BURIAL  |  | 23b. DATE<br>1-9-85   |  | 23c. NAME OF CEMETERY OR CREMATORY<br>CEDAR HILL Cem.   |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>BALTO. MD.                      |  |
| 24. FUNERAL DIRECTOR<br>NAME<br>F. E. Chatham - 7527 Harford Rd.  |  | 25a. DATE REC'D. BY REGISTRAR<br>JAN 8 1985   |  | 25b. REGISTRAR'S SIGNATURE<br>Jana Davidson-Rendall   |  | 25c. REGISTRAR'S NAME<br>Jana Davidson-Rendall                                |  |

BP

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 4 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.



104

1-2-35 JAMES T. WILSON

35 0-24-1935

WILSON, JAMES T. 104

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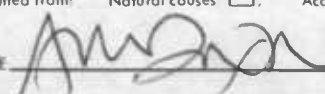
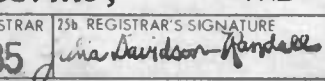
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STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

1- FOR  
STATE  
REGISTRAR

|  |                            |  |   |   |
|--|----------------------------|--|---|---|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br><b>ALEXANDRA C. WILKINS</b>   |                            | 2a. DATE KNOWN OF DEATH<br>MONTH <b>1</b> DAY <b>3</b> YEAR <b>1985</b>  |   | 2b. HOUR<br><b>11:42</b> a.m.   |
| 3. SEX<br><b>F</b>   | 4. RACE<br><b>W</b>        | 5. DATE OF BIRTH<br>MONTH <b>5</b> DAY <b>26</b> YEAR <b>20</b>  | 6. AGE (IN YEARS)<br>LAST BIRTHDAY <b>64</b> YRS.   | 7. IF UNDER 1 YR.<br>MONTHS <b>0</b> DAYS <b>0</b>  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>PA</b>   |                            | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>   |   | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> |
| 9. CITY OR TOWN OF DEATH<br><b>Baltimore</b>   |                            | 10. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>University Hospital</b> |   | 11. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Waitress -- Restaurant</b>   |
| 12. USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE <b>MD</b> 13b. COUNTY <b>Balto.</b> 13c. CITY OR TOWN <b>Randallstown</b>   |                            | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |   | 13e. STREET ADDRESS<br><b>8619 Dovedale Rd., 21133</b>  |
| 14. FATHER'S NAME<br>FIRST <b>Konstanty</b> MIDDLE <b>Wroblewski</b> LAST <b>Wroblewski</b>  |                            | 15. MOTHER'S MAIDEN NAME<br>FIRST <b>Anna</b> MIDDLE <b>Staskiewicz</b> LAST <b>Staskiewicz</b>  |   |   |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO, OR UNKNOWN)<br><b>No</b>   |                            | 16b. SOCIAL SECURITY NO.<br><b>179 14 0784</b>   |   | 17. INFORMANT<br>ADDRESS<br><b>Edward Wroblewski, MD</b>  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Corrosive ingestion with complications</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost:<br>(b)<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c)<br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH                       |                            |  |   |   |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).  |                            |  |   |   |
| 19a. DATE OF OPERATION   |                            | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?  |   | 20. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |
| 21a. EXTERNAL CAUSE WAS<br>UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH   |                            | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>11:34xx 11-29-19 84</b>  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)<br><b>Subject ingested caustic substance.</b> |   |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>   |                            | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)<br><b>home</b>   | 21f. LOCATION<br>STREET <b>8619 Dovedale Rd.,</b> CITY OR TOWN <b>Randallstown,</b> COUNTY <b>Balto.,</b> STATE <b>Md.</b>  |   |
| 22a. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> |                            |  |   |   |
| ACTUAL SIGNATURE<br>  |                            | TITLE (SPECIFY)<br>M.D. <b>Assistant</b> MEDICAL EXAMINER  |   | DATE SIGNED <b>1-4-85</b>   |
| EXAMINER'S NAME (TYPE OR PRINT)<br><b>Ann M. Dixon, M.D.</b>   |                            | ADDRESS <b>111 Penn St., Balto., Md. 21201</b>   |   |   |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>Burial</b>   | 23b. DATE<br><b>1/5/85</b> | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Druid Ridge</b>   |   | 23d. LOCATION<br>CITY OR TOWN <b>Pikesville,</b> COUNTY <b>MD</b> STATE <b>MD</b>   |
| 24. FUNERAL DIRECTOR<br>NAME <b>Henry W. Jenkins &amp; Sons Co.</b><br>ADDRESS <b>4905 York Road Balto., MD 21212</b>  |                            | 25a. DATE REC'D. BY REGISTRAR<br><b>JAN 4 1985</b>   |   | 25b. REGISTRAR'S SIGNATURE<br>   |

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL, TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

3 PHOENIX, AZ

W. B. 20

USA

Waitress - Restaurant

1110 1st Ave. S.E., Atlanta, GA

MD. Baltimore, Md.

Ken. Wroblewski, Anna, State of Ga.

No. 175 14-0784 Edward Wroblewski, MD

*Wroblewski*

Surf 1563 - Drive Road, P.O. Box 111

Henry W. Jenkins & Son Co.,  
400 York Road, Baltimore, MD 21202

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 5 0 1 / 0 8

1. FOR  
STATE  
REGISTRAR

REG. NO.

|   |                         |  |   |   |                            |
|---|-------------------------|--|---|---|----------------------------|
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>Bernard Zack Williams</b>  |                         |  | 2a. DATE OF DEATH MONTH - DAY YEAR<br><b>January 14, 1985</b> |   | 2b. HOUR<br><b>3:45 A.</b> |
| 3. SEX<br><b>Male</b>   | 4. RACE<br><b>White</b> | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>April 26, 1926</b>                          |   | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>58</b>  |                            |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Charlotte Hall, Md. - U.S.A.</b>  |                         | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>  |   | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>       |                            |
| 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore City,</b>  |                         | 10. CITY OR TOWN OF DEATH<br><b>Baltimore</b>  |   | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br><b>1937 Grinnalds Avenue</b>   |                            |
| 12a. USUAL OCCUPATION<br>(TYPE OF WORK OR MOST OF WORKING HRS)<br><b>Truck Driver</b>   |                         | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>Freight Line</b>                             |   | 13a. STATE<br><b>Md.</b>  |                            |
| 13b. COUNTY<br><b>---</b>   |                         | 13c. CITY OR TOWN<br><b>Baltimore</b>  |   | 13d. INSIDE CITY LIMITS?<br><b>YES</b> <input checked="" type="checkbox"/> <b>NO</b> <input type="checkbox"/>   |                            |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>J. Alvin Williams</b>  |                         | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Rose Belle Swann</b>             |   | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>Yes</b>  |                            |
| 16b. SOCIAL SECURITY NO.<br><b>220-14-0704</b>  |                         | 17. INFORMANT<br><b>1937 Grinnalds Ave., Balto., Md.</b>                             |   | 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>CARDIO RESPIRATORY FAILURE</b> |                            |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last   |                         | DUE TO, OR AS A CONSEQUENCE OF (b) <b>CARCINOMATOSIS</b>                             |   | DUE TO, OR AS A CONSEQUENCE OF (c) <b>CARCINOMA OF COLON</b>  |                            |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)   |                         |  |   |   |                            |
| 19a. DATE OF OPERATION<br><b>12.19.84</b>   |                         | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED<br><b>COLON OBSTRUCTION</b>         |   | 20a. AUTOPSY?<br><b>YES</b> <input type="checkbox"/> <b>NO</b> <input checked="" type="checkbox"/>  |                            |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |                         | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>19</b>                         |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)<br><b>---</b>  |                            |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>   |                         | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)<br><b>---</b> |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE<br><b>---</b>   |                            |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>2.21.1984</b> to <b>1.15.1985</b> , that (I) (we) last saw the deceased alive on <b>1.31.1985</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (I) (we) (did) (did not) view the body after death. |                         |  |   |   |                            |
| 22b. SIGNATURE<br><b>Keith Faccia</b>   |                         | DEGREE<br><b>---</b>   |   | 22c. DATE SIGNED<br><b>1/15/85</b>  |                            |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>KEITH FACCIA</b>  |                         | 22e. ADDRESS<br><b>3356 Wilbur</b>   |   | 22f. SIGNATURE<br><b>Clown</b>  |                            |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>Burial</b>  |                         | 23b. DATE<br><b>1/16/85</b>  |   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Meadowridge Mem Park</b>   |                            |
| 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Balto., Howard Cty, Md.</b>  |                         | 24. FUNERAL DIRECTOR<br>NAME ADDRESS<br><b>Sterling Funeral Estate, P.A.</b>         |   | 25a. DATE REC'D. BY REGISTRAR<br><b>JAN 18 1985</b>   |                            |
| 25b. REGISTRAR'S SIGNATURE<br><b>J. Davidson-Randall</b>  |                         | 26. REGISTRAR'S SIGNATURE<br><b>J. Davidson-Randall</b>                              |   |   |                            |

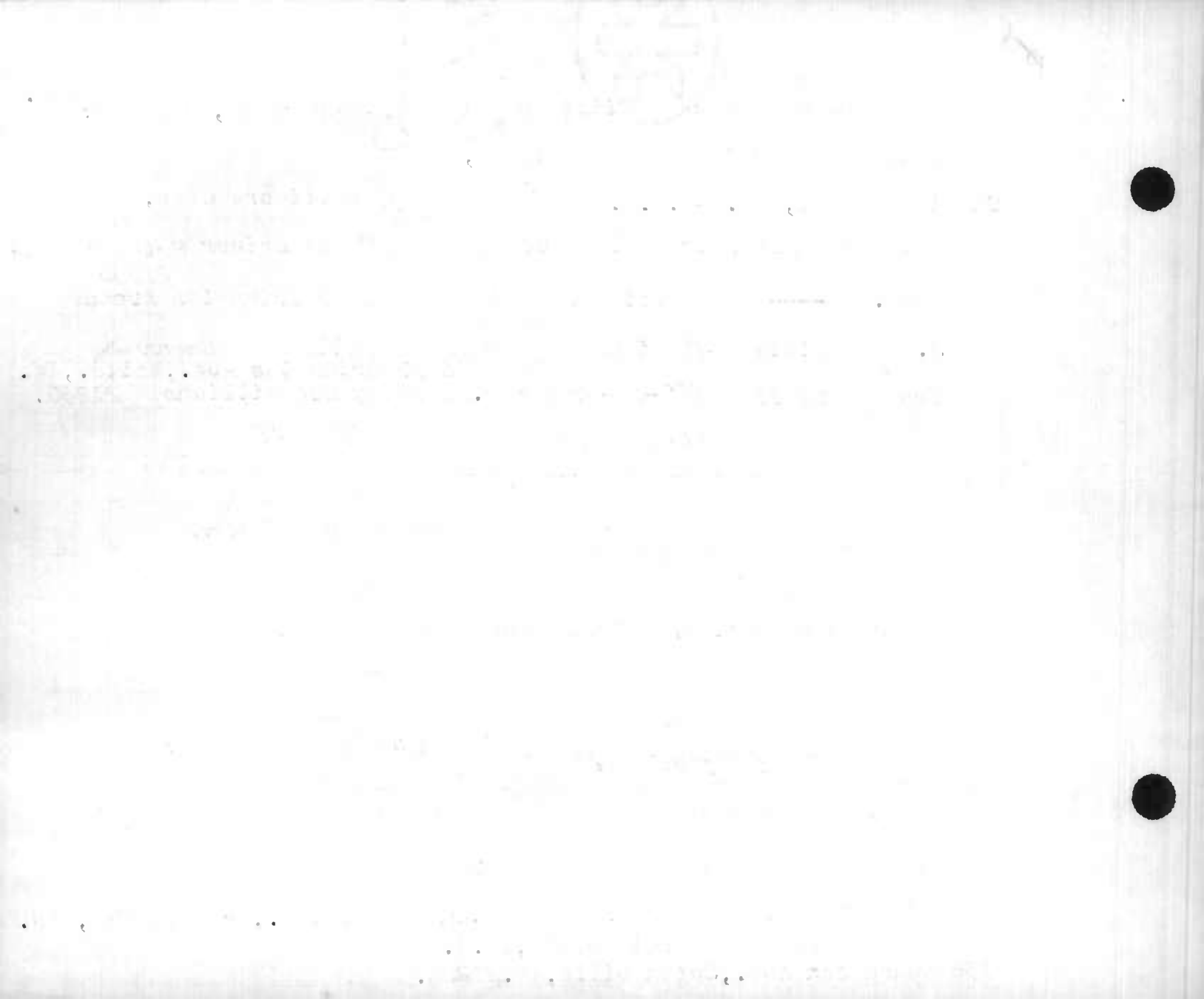
350  
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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 1 should be detached for use as the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.



5 188 58 01

TO HOSPITAL OR ATTENDING PHYSICIAN. The law requires that the death certificate be executed within 24 hours after death. Possession may be retained by the hospital or attending physician.

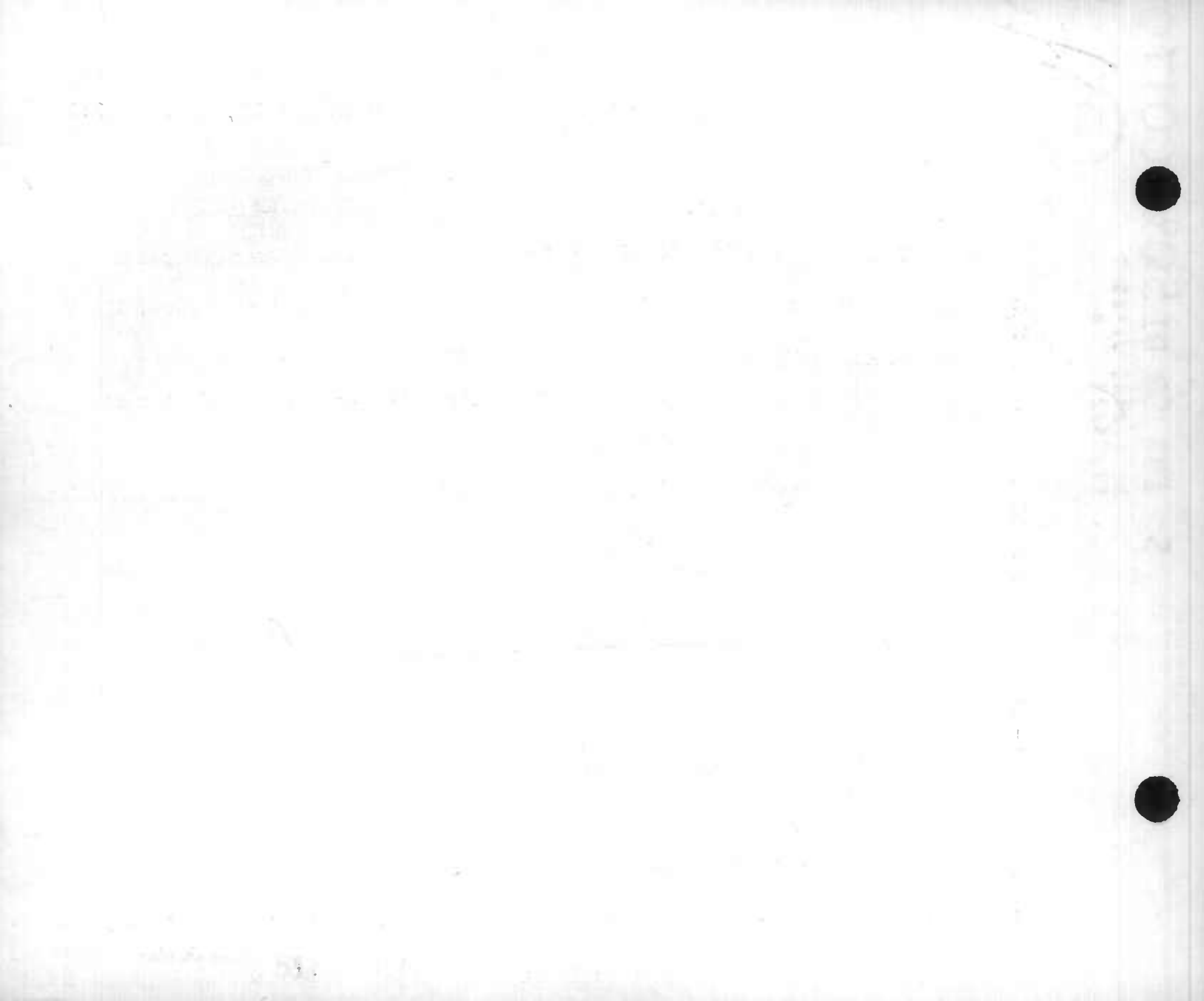
TO FUNERAL DIRECTOR. After this certificate has been signed by the attending physician, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene, either to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

RELEASED AS NON-MEDICAL SYNTH PER MR RICHARDSON

## MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH   |  |   |  | REG. NO.   |  |   |  |
|--|--|---|--|--|--|---|--|
| 1. FOR STATE REGISTRAR   |  |   |  | 2a. DATE OF DEATH MONTH DAY YEAR   |  |   |  |
| 1. DECEASED NAME FIRST MIDDLE LAST<br>JAMES T WILLIAMS   |  |   |  | JANUARY 30, 1985   |  |   |  |
| 3. SEX Male  |  |   |  | 4. RACE White  |  |   |  |
| 5. DATE OF BIRTH MONTH DAY YEAR<br>Feb 4, 1920   |  |   |  | 6. AGE (IN YEARS LAST BIRTHDAY) 64 YRS.  |  |   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Tenn  |  |   |  | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.A.   |  |   |  |
| 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>  |  |   |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>BALTIMORE CITY MD.   |  |   |  |
| 10. CITY OR TOWN OF DEATH<br>BALTIMORE   |  |   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>JOHNS HOPKINS HOSPITAL                          |  |   |  |
| 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Retired Press Operator   |  |   |  | 12b. KIND OF BUSINESS OR INDUSTRY  |  |   |  |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE Maryland 13b. COUNTY Howard 13c. CITY OR TOWN Elkridge  |  |   |  | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>  |  |   |  |
| 14. FATHER'S NAME FIRST MIDDLE LAST<br>late James F Williams   |  |   |  | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST<br>late Jean Harbin   |  |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)<br>Yes WW 11   |  |   |  | 16b. SOCIAL SECURITY NO.<br>409 20 6067  |  |   |  |
| 17. INFORMANT ADDRESS<br>Mrs Helen Williams 6220 Washington Blvd   |  |   |  |  |  |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) Hemorrhage<br>DUE TO, OR AS A CONSEQUENCE OF (b) Esophageal & Probable Aortic erosion 6 mos<br>DUE TO, OR AS A CONSEQUENCE OF (c) Esophageal Carcinoma 4 yrs.                     |  |   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br>< 24 hrs.  |  |   |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a.  |  |   |  |  |  |   |  |
| 19a. DATE OF OPERATION<br>4/28/85 / 1/30/85  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED<br>Esophageal Obstruction/Bleeding |  | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR<br>P.M. 19                             |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)   |  |   |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                 |  | 21f. LOCATION CITY OR TOWN COUNTY STATE  |  |   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from 1/26, 19 85, to 1/30, 19 85, that (I) (we) lost saw the deceased alive on 1/30, 19 85, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |  |   |  |  |  |   |  |
| 22b. SIGNATURE<br>Robert Park  |  |   |  | DEGREE<br>M.D.<br>ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> |  | 22c. DATE SIGNED<br>1/30/85   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>Robert Park   |  |   |  | 22e. ADDRESS<br>Johns Hopkins Hospital, Balt. MD   |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>Burial  |  | 23b. DATE<br>Feb 4, 1985  |  | 23c. NAME OF CEMETERY OR CREMATORY<br>Garrison Forest Vets.  |  | 23d. LOCATION CITY OR TOWN COUNTY STATE<br>Garrison Forest Maryland   |  |
| 24. FUNERAL DIRECTOR NAME<br>Harry H Witzke 4112 Columbia Rd Ellicott City   |  |   |  | 25a. DATE REC'D. BY REGISTRAR<br>FEB 4 1985  |  |   |  |
| 25b. REGISTRAR'S SIGNATURE<br>John Richardson-Randall  |  |   |  |  |  |   |  |





TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER, ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>MEDICAL EXAMINER'S CERTIFICATE OF DEATH  |                      |   |   |  |                                      |   |  |  |  | REG. NO. 01710  |  |
|--|----------------------|---|---|--|--------------------------------------|---|--|--|--|---|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>Kinya Williams</b>  |                      |   |   |  |                                      |   |  |  |  | 2a. DATE KNOWN OF DEATH <input checked="" type="checkbox"/> ESTIMATED <input type="checkbox"/> <b>1/28/1985</b> |  |
| 3. SEX <b>Female</b>   | 4. RACE <b>Black</b> | 5. DATE OF BIRTH<br>MONTH DAY YEAR <b>10 -10- 1984</b>  | 6. AGE (IN YEARS)<br>LAST BIRTHDAY MONTHS DAYS YRS. <b>3 18</b> | IF UNDER 1 YR<br>MONTHS DAYS <b>3 18</b>   | IF UNDER 24 HRS<br>HOURS MIN <b></b> | 2c. DATE PRONOUNCED DEAD <b>1/28/1985</b>   |  | 2d. HOUR <b>10:30 A</b>  |  |   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Baltimore</b>   |                      | 7b. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>  |   | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |                                      | 9. BALTIMORE CITY OR COUNTY OF DEATH <b>Baltimore City,</b> MD.                   |  |  |  |   |  |
| 10. CITY OR TOWN OF DEATH <b>Baltimore</b>   |                      | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>University Hospital</b> |   |  |                                      | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)                     |  | 12b. KIND OF BUSINESS OR INDUSTRY  |  |   |  |
| 13a. STATE <b>Maryland</b>   |                      | 13b. COUNTY <b>BALTO</b>  |   | 13c. CITY OR TOWN <b>BALTO</b>   |                                      | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/> |  | 13e. STREET ADDRESS <b>913 Seagull Ave.</b> <b>21225</b>                         |  |   |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST <b>Douglass Maxmore</b>   |                      |   |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST <b>Tujuana Williams</b>  |                                      |   |  |  |  |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)   |                      |   |   | 16b. SOCIAL SECURITY NO.   |                                      | 17. INFORMANT ADDRESS <b>Tujuana Williams 913 Seagull Ave.</b>                    |  |  |  |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1 DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Sudden Infant Death Syndrome</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last:<br>(b) <b></b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <b></b><br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH   |                      |   |   |  |                                      |   |  |  |  |   |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1   |                      |   |   |  |                                      |   |  |  |  |   |  |
| 19a. DATE OF OPERATION   |                      | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?   |   |  |                                      |   |  | 20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |   |  |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH  |                      | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. <b>19</b>   |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)  |                                      |   |  |  |  |   |  |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>   |                      | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)   |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE  |                                      |   |  |  |  |   |  |
| 22a. I certify that I took charge of the remains described above, held on <u>Autopsy</u> <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: <u>Natural causes</u> <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> . |                      |   |   |  |                                      |   |  |  |  |   |  |
| ACTUAL SIGNATURE <b>[Signature]</b>  |                      | TITLE (SPECIFY) <b>Assistant</b> M.D.   |   |  |                                      | MEDICAL EXAMINER  |  | DATE SIGNED <b>1/29/85</b>   |  |   |  |
| EXAMINER'S NAME (TYPE OR PRINT) <b>Gregory R. Kauffman, M.D.</b>   |                      | ADDRESS <b>111 Penn St.</b>   |   |  |                                      |   |  |  |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>  |                      | 23b. DATE <b>2-2-85</b>   |   | 23c. NAME OF CEMETERY OR CREMATORY <b>Cedar Hill Cemetery</b>  |                                      | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE <b>Anne Arundel Maryland</b>           |  |  |  |   |  |
| 24. FUNERAL DIRECTOR<br>NAME ADDRESS <b>Carlton C. Douglass 1348 N. Calhoun St. 21217</b>  |                      |   |   | 25a. DATE REC'D. BY REGISTRAR <b>FEB 4 1985</b>  |                                      | 25b. REGISTRAR'S SIGNATURE <b>Juha Davidson-Randall</b>                           |  |  |  |   |  |



GRAND

MILWAUKEE

MADE IN

U.S.A.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 1 and 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH  |  |  |  |  | 8 5 0 1 7 1 1  |  |
|---|--|--|--|--|--|--|
| 1- STATE REGISTRAR  |  |  |  |  | REG. NO.   |  |
| 1. DECEASED NAME<br>(TYPE OR PRINT) <i>Melvin P. Williams</i>   |  |  |  |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><i>1 31 85</i>  |  |
| 3. SEX<br><i>Male</i>   |  |  |  |  | 2b. HOUR<br><i>1030 PM</i>   |  |
| 4. RACE<br><i>Black</i>   |  |  |  |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><i>66</i> YRS.  |  |
| 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><i>6 18 18</i>  |  |  |  |  | IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS.<br>HOURS MIN.   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><i>Maryland</i>  |  |  |  |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><i>Baltimore City</i> MD.  |  |
| 7b. CITIZEN OF WHAT COUNTRY?<br><i>U. S. A.</i>   |  |  |  |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><i>General Electric</i>   |  |
| 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>   |  |  |  |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><i>Forklift Operator</i>   |  |
| 10. CITY OR TOWN OF DEATH<br><i>Baltimore</i>   |  |  |  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><i>Lutheran Hospital</i>                          |  |
| 13a. STATE<br><i>md</i>   |  |  |  |  | 13b. COUNTY<br><i>Balt</i>   |  |
| 13c. CITY OR TOWN<br><i>Balt</i>  |  |  |  |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>  |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><i>Robert Williams</i>  |  |  |  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><i>Annie Strange</i>  |  |
| 16a. WAS DECEASED EVER IN U. S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)   |  |  |  |  | 16b. SOCIAL SECURITY NO.<br><i>220-09-0577</i>   |  |
| 17. INFORMANT<br>ADDRESS<br><i>2210 N. Rosedale St.</i>   |  |  |  |  | 17. INFORMANT<br>NAME<br><i>Precious S. Williams</i>   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <i>Cardio respiratory failure</i><br>DUE TO, OR AS A CONSEQUENCE OF (b) <i>Carcinoma bladder with metastasis &amp; renal failure</i><br>DUE TO, OR AS A CONSEQUENCE OF (c) <i>Renal failure</i> |  |  |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH   |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <i>Renal failure</i>   |  |  |  |  |  |  |
| 19a. DATE OF OPERATION  |  |  |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  |
| 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  |  |  |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>                                     |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  |  |  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><i>19</i>   |  |
| 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |  |  |  |  | 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/> |  |
| 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  |  |  |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <i>1/31/85</i> to <i>1/31/85</i> , that (I) (we) last saw the deceased alive on <i>1/31/85</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.    |  |  |  |  |  |  |
| 22b. SIGNATURE<br><i>Dr. Howard</i>   |  |  |  |  | 22c. DATE SIGNED   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><i>Dr. Howard</i>  |  |  |  |  | 22e. ADDRESS<br><i>Lutheran Hosp.</i>  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><i>Burial</i>  |  |  |  |  | 23b. DATE<br><i>2/7/1985</i>   |  |
| 23c. NAME OF CEMETERY OR CREMATORY<br><i>Garrison Forest Veterans Cemetery</i>  |  |  |  |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><i>Baltimore, Md.</i>  |  |
| 24. FUNERAL HOME<br>NAME ADDRESS<br><i>Nutter &amp; Sons 2501 Gwynns Falls Parkway</i><br><i>Funeral Home Inc. Baltimore, Maryland 21216</i>  |  |  |  |  | 25a. DATE REC'D. BY REGISTRAR<br><i>FEB 7 1985</i>   |  |
| 25b. REGISTRAR'S SIGNATURE<br><i>Jane Davidson-Randall</i>  |  |  |  |  |  |  |

7

Maryland  
U. S. A.  
Black

Baltimore City  
General  
Telephone Operator  
2210 N. Roseville Street  
Baltimore, Maryland 21216

Robert  
Williams  
100-04-0577  
2210 N. Roseville St.  
Baltimore, Md. 21216

20% OFF  
CASH  
SALE  
10/10/68

General Home Inc. Baltimore, Maryland 21216  
Butter & Sons 2501 Gwynn Falls Parkway  
27/1968  
Veterans Cemetery  
Baltimore, Md.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner is to be called at once.

## MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE  |                  |   |   | 8 5 0 1 7 1 2   |   |
|---|------------------|---|---|---|---|
| 1. FOR STATE REGISTRAR  |                  |   |   | REG. NO.  |   |
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>Nehemiah W. Williams   |                  |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br>1 - 7 - 1985             |   | 2b. HOUR<br>M   |
| 3. SEX<br>Male  | 4. RACE<br>Black | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>11 - 15 - 1914  |   | 6. AGE (IN YEARS LAST BIRTHDAY)<br>70 YRS.  |   |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Baltimore  |                  | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.A.  |   | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |   |
| 10. CITY OR TOWN OF DEATH<br>Baltimore  |                  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>2519 Garrison Blvd |   | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Baltimore city MD.  |   |
| 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Maintenance   |                  |   | 12b. KIND OF BUSINESS OR INDUSTRY                               |   |   |
| 13a. STATE<br>Maryland  |                  |   | 13b. COUNTY   | 13c. CITY OR TOWN<br>City   | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>James J. Williams   |                  |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Isdore Groomes |   |   |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)<br>No  |                  | 16b. SOCIAL SECURITY NO.<br>212-03-7407   |   | 17. INFORMANT<br>Garlie C. Williams 2519 Garrison Blvd 21216  |   |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) Acute Myocardial Infarction<br>DUE TO, OR AS A CONSEQUENCE OF (b)<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>DUE TO, OR AS A CONSEQUENCE OF (c) |                  |   |   |   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)<br>Arteriosclerotic Cardiovascular Disease   |                  |   |   |   |   |
| 19a. DATE OF OPERATION  |                  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>   |   |
| 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>  |                  |   |   |   |   |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |                  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)   |   |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK   |                  | 21e. PLACE OF INJURY<br>(AT HOME STREET, FACTORY, OFFICE, FARM, ETC.)   |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |   |
| 22a. I certify that (I) (this hospital) attended the deceased from 4/21, 1985, to 4/27, 1985, that (I) (we) last saw the deceased alive on 4/27, 1985, and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) did (did not) view the body after death.                               |                  |   |   |   |   |
| 22b. SIGNATURE<br>Seymour B. Elman MD   |                  | DEGREE<br>MD  |   | 22c. DATE SIGNED<br>4/7/85  |   |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>SEYMOUR B. ELMAN   |                  | 22e. ADDRESS<br>3023 Gwyn Ave Balt Md 21224   |   |   |   |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br>Burial  |                  | 23b. DATE<br>1-12-85  |   | 23c. NAME OF CEMETERY OR CREMATORY<br>Western Star Cemetery   |   |
| 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Baltimore City, MD  |                  | 24. FUNERAL DIRECTOR<br>NAME ADDRESS<br>Vernon R. Bailey 1348 N. Calhoun St. 21217  |   |   |   |
| 25a. DATE REC'D. BY REGISTRAR<br>JAN 9 1985   |                  | 25b. REGISTRAR'S SIGNATURE<br>John Davidson-Randall   |   |   |   |

BP

ORIGINAL FILE



CHIEF

20% COAL

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE  |  |   |  | 8 5 0 1 7 1 3  |  |  |  |
|---|--|---|--|--|--|--|--|
| F 1. FOR STATE REGISTRAR  |  |   |  | REG. NO.   |  |  |  |
| 1 DECEASED NAME<br>(TYPE OR PRINT) <b>CHARLES WILLIAMSON</b>  |  |   |  | 2a DATE OF DEATH   |  | 2b HOUR  |  |
|   |  |   |  | 1 13 85  |  | 10:00 <sup>P</sup>   |  |
| 3 SEX<br><b>Male</b>  |  | 4 RACE<br><b>White</b>  |  | 5. DATE OF BIRTH   |  | 6 AGE (IN YEARS LAST BIRTHDAY)   |  |
|   |  |   |  | 9 17 22  |  | 62 YRS.  |  |
| 7a BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>West Virginia</b>  |  | 7b CITIZEN OF WHAT COUNTRY?<br><b>U.S.</b>  |  | 8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9 BALTIMORE CITY OR COUNTY OF DEATH<br><b>Balto. City</b> MD.  |  |
| 10 CITY OR TOWN OF DEATH<br><b>Balto.</b>   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>600 E. 33rd St.</b> |  | 12a USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Teacher</b>  |  | 12b KIND OF BUSINESS OR INDUSTRY<br><b>City Schools</b>  |  |
| 13a STATE<br><b>Md.</b>   |  | 13b COUNTY  |  | 13c CITY OR TOWN<br><b>Balto.</b>  |  | 13d INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                             |  |
| 14 FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>William Williamson</b>  |  | 15 MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Marie Beavers</b>  |  | 13e STREET ADDRESS<br><b>600 E. 33rd St. 21218</b>   |  |  |  |
| 16a WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) <b>No</b>   |  | 16b SOCIAL SECURITY NO.<br><b>215-16-0031</b>   |  | 17 INFORMANT ADDRESS<br><b>Mrs. Vivian Williamson - Same as #13</b>  |  |  |  |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>metastatic carcinoma of tongue</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last |  |   |  |  |  |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <b>Cachexia. Pernicious anemia Bladder cancer</b>  |  |   |  |  |  |  |  |
| 19a DATE OF OPERATION<br><b>1982</b>  |  | 19b CONDITION FOR WHICH OPERATION WAS PERFORMED<br><b>Cat tongue biopsy</b>   |  | 20a AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>  |  | 21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |  |  |  |
| 21d INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK   |  | 21e PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |  | 21f LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |  |  |
| 22a I certify that (I) (this hospital) attended the deceased from <b>2/8 1981</b> to <b>1/13 1985</b> , that (I) (we) lost saw the deceased alive on <b>1/14/85</b> 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.                                |  |   |  |  |  |  |  |
| 22b SIGNATURE<br><b>Samuel E. Lurie</b>   |  | DEGREE<br><b>MD</b>   |  | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>                 |  | 22c DATE SIGNED<br><b>1/12/85</b>  |  |
| 23a BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>Removal</b>  |  | 23b DATE<br><b>1/14/85</b>  |  | 23c NAME OF CEMETERY OR CREMATORY  |  | 23d LOCATION<br>CITY OR TOWN COUNTY STATE  |  |
| 24 FUNERAL DIRECTOR<br>NAME<br><b>Anatomy Board</b>   |  | ADDRESS<br><b>Balto., Md.</b>   |  | 25a DATE REC'D. BY REGISTRAR<br><b>JAN 28 1985</b>   |  | 25b REGISTRAR'S SIGNATURE<br><b>Julia Davidson-Randall</b>   |  |





STATE OF MARYLAND

DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 5 0 1 7 1 4

REG. NO.

1. FOR  
STATE  
REGISTRAR

|  |  |   |   |  |   |
|--|--|---|---|--|---|
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>CORNELIUS I. WILSON, JR.</b>  |  |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR <b>1-23-85</b>                      |  | 2b. HOUR<br><b>10:15P M</b>                                     |
| 3. SEX<br><b>MALE</b>  | 4. RACE<br><b>BLACK</b>  | 5. DATE OF BIRTH<br>MONTH DAY YEAR <b>9-13-17</b>   |   | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>67</b> YRS.                              |   |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>MARYLAND</b>   | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>   | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>BALTIMORE CITY</b> MD.              |   |
| 10. CITY OR TOWN OF DEATH<br><b>Baltimore</b>  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>BON SECOURS HOSPITAL</b> |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)        |  | 12b. KIND OF BUSINESS OR INDUSTRY                               |
| 13a. STATE<br><b>MD</b>  |  |   | 13b. COUNTY<br><b>Baltimore</b>   | 13c. CITY OR TOWN<br><b>Baltimore</b>  |   |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>CORNELIUS I. WILSON, SR.</b>  |  |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>NANNIE PETERSON</b> |  |   |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>NO</b>  |  | 16b. SOCIAL SECURITY NO.<br><b>217-09-2839</b>  |   | 17. INFORMANT<br>ADDRESS<br><b>Louise Hicks 2830 Parkwood Ave</b>              |   |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Metastatic bronch carcinoma, primary unknown</b><br>DUE TO, OR AS A CONSEQUENCE OF (b) _____<br>DUE TO, OR AS A CONSEQUENCE OF (c) _____<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last |  |   |   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>2 months</b> |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)<br><b>Diabetes mellitus, HDP</b>  |  |   |   |  |   |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>      |   |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) |   |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                              |   |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>1/23</b> 19 <b>85</b> , to <b>1/24</b> 19 <b>85</b> , that (I) (we) last saw the deceased alive on <b>1/23</b> 19 <b>85</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.                 |  |   |   |  |   |
| 22b. SIGNATURE<br><b>Jamer Evans MD</b>  |  | DEGREE  |   | 22c. DATE SIGNED<br><b>1/24/85</b>   |   |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>Jamer Evans MD</b>   |  | 22e. ADDRESS<br><b>700 Washington Blvd, Balto, MD 21201</b>   |   |  |   |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>Burial</b>  | 23b. DATE<br><b>1/28/85</b>  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Mt. Calvary Cem.</b>   |   | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Anne Arundel Co. MD</b>       |   |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>Wm. C. March F/H</b>  |  | ADDRESS<br><b>1101 E. North Ave.</b>  |   | 25a. DATE REC'D. BY REGISTRAR<br><b>JAN 25 1985</b>                            |   |
|  |  |   |   | 25b. REGISTRAR'S SIGNATURE<br><b>Lelia Davidson-Randall</b>                    |   |

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 2 and 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked on item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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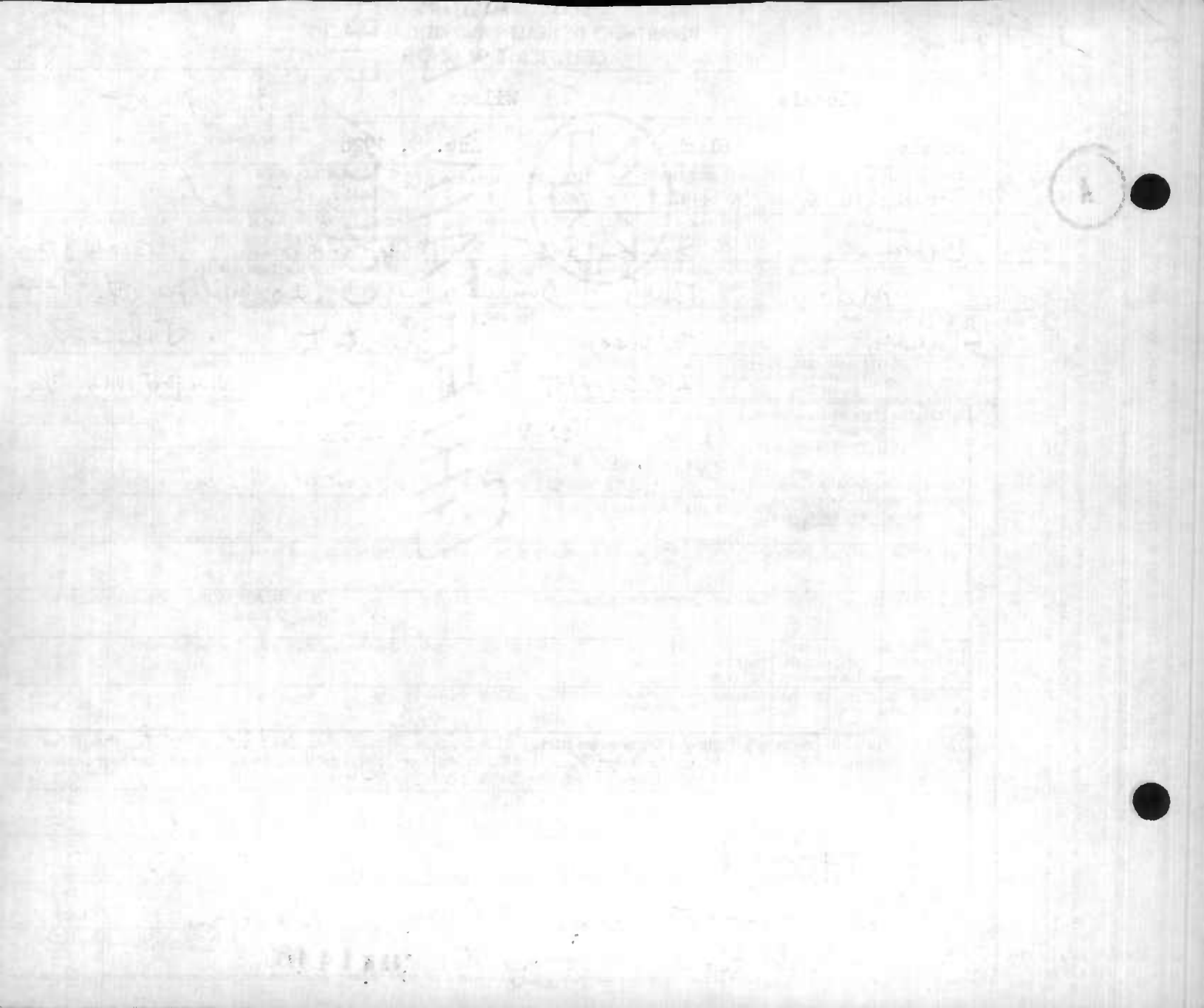
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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal, and in any event, within 72 hours after death.

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

|  |  |  |  |  |  |   |  |  |  |  |  |
|--|--|--|--|--|--|---|--|--|--|--|--|
| 1. DECEASED NAME<br>(Type or print) <b>Flossie</b>   |  |  | First Middle Last <b>Wilson</b>  |  |  | 2a. DATE OF DEATH<br>Month <b>1</b> Day <b>9</b> Year <b>85</b>   |  |  | 2b. HOUR<br>M  |  |  |
| 3. SEX<br><b>Female</b>  |  |  | 4. RACE<br><b>Black</b>  |  |  | 5. DATE OF BIRTH<br><b>Aug. 8, 1928</b>   |  |  | 6. AGE (In years last birthday)<br><b>56</b> YRS.                                    |  |  |
| 7a. BIRTHPLACE (State or foreign country)<br><b>Farmville, Va.</b>   |  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>  |  |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  |  | 9. COUNTY OF DEATH<br><b>Balto. city</b>   |  |  |
| 10. CITY OR TOWN OF DEATH<br><b>Baltimore</b>  |  |  | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)<br><b>Francis Scott Key</b> |  |  | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)<br><b>Clerk</b>   |  |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>Board of Education</b>                       |  |  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE<br><b>Md.</b>  |  |  | 13b. COUNTY<br><b>Balto.</b>   |  |  | 13c. CITY OR TOWN<br><b>Dundalk.</b>  |  |  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |  |
| 13e. STREET AND NUMBER<br><b>120 Willow Ct. 21222</b>  |  |  | 14. FATHER'S NAME<br>First Middle Last<br><b>Stanley Wilson</b>  |  |  | 15. MOTHER'S MAIDEN NAME<br>First Middle Last<br><b>Elizabeth Johnson</b>   |  |  |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(Yes, no, or unknown)  |  |  | 16b. SOCIAL SECURITY NO.<br><b>218-22-4757</b>   |  |  | 17. INFORMANT<br><b>Joseph Ford</b>   |  |  | Address<br><b>Newport News Va.</b>   |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Acute Cordeoc Arrest</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(b) <b>Hypertensive Cardiovascular Disease</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) |  |  |  |  |  |   |  |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)  |  |  |  |  |  |   |  |  |  |  |  |
| 19a. DATE OF OPERATION   |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  |  | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?                 |  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(If either, notify medical examiner)  |  |  | 21b. TIME OF INJURY<br>Hour A.M. Month Day Year<br>P.M. 19   |  |  | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)   |  |  |  |  |  |
| 21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/><br>at work at work  |  |  | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)                             |  |  | 21f. LOCATION Street or R.F.D. No. City or Town County State  |  |  |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>4/14/66</b> , 19 <b>84</b> , to <b>10/24</b> , 19 <b>84</b> , that (I) (we) lost the deceased on <b>4/14/66</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. <b>10/24/84</b>                           |  |  |  |  |  |   |  |  |  |  |  |
| 22b. SIGNATURE<br><b>Theoc Patterson MD</b>  |  |  |  |  |  | 22c. DATE SIGNED<br><b>1/11/85</b>  |  |  |  |  |  |
| 22d. PHYSICIAN'S NAME (Type)<br><b>THEOC PATTERSON</b>   |  |  |  |  |  | 22e. ADDRESS<br><b>5457 Dundalk Ave 21222</b>   |  |  |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>   |  |  | 23b. DATE<br><b>1-12-85</b>  |  |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Cedar Hill Cem.</b>  |  |  | 23d. LOCATION (City or Town) (County) (State)<br><b>Baltimore Md.</b>                |  |  |
| 24. FUNERAL DIRECTOR<br><b>James A. Morton &amp; Son</b>   |  |  |  |  |  | ADDRESS<br><b>1701 Bouquies St. Balto</b>   |  |  | 25a. REC'D BY REGISTRAR<br>DATE <b>JAN 14 1985</b>                                   |  |  |
|  |  |  |  |  |  | 25b. REGISTRAR'S SIGNATURE<br><b>John A. ...</b>  |  |  |  |  |  |



STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 5 0 1 7 1 6

FOR  
STATE  
REGISTRAR

REG. NO.

|  |  |  |  |   |  |   |  |  |  |
|--|--|--|--|---|--|---|--|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br><i>Bessie Winner</i>  |  |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><i>1/3/85</i>                   |   |  | 2b. HOUR<br><i>4:15 PM</i>  |  |  |  |
| 3. SEX<br><i>Female</i>  |  | 4. RACE<br><i>White</i>  |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><i>3/136/1909</i>   |  | 6. AGE (IN YEARS (LAST BIRTHDAY))<br><i>75</i> YRS.   |  | IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS.<br>HOURS MIN.   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><i>MARYLAND</i>   |  | 7b. CITIZEN OF WHAT COUNTRY?<br><i>USA</i>   |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><i>BALTIMORE CITY</i> MD.                               |  |  |  |
| 10. CITY OR TOWN OF DEATH<br><i>BALTIMORE</i>  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><i>MERCY HOSPITAL</i> |  |   |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><i>SALESPERSON</i>          |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><i>STEWARTS</i>   |  |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE<br><i>MARYLAND</i>   |  | 13b. COUNTY  |  | 13c. CITY OR TOWN<br><i>BALTIMORE</i>   |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 13e. STREET ADDRESS<br><i>5616 BENTON HEIGHTS AVE. 21206</i>   |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><i>SIMON GLEIMAN</i>   |  |  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><i>YETTA KIRSCHENBAUM</i>  |  |   |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><i>NO</i>  |  | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br><i>213-16-5162</i>  |  | 17. INFORMANT<br><i>WILBUR WINNER</i><br><i>5616 BENTON HEIGHTS AVE. BALTO., MD 21206</i>   |  |   |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <i>Renal failure</i><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(b) <i>Rapidly progressive glomerulonephritis</i><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____<br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><i>1 1/2 mo</i> |  |  |  |   |  |   |  |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a.  |  |  |  |   |  |   |  |  |  |
| 19a. DATE OF OPERATION   |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                       |   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>            |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. <i>19</i>      |   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)                  |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  |  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) |   |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <i>11/9</i> 19 <i>84</i> , to <i>1/3</i> 19 <i>85</i> , that (I) (we) last saw the deceased alive on <i>1/3</i> 19 <i>85</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.   |  |  |  |   |  |   |  |  |  |
| 22b. SIGNATURE<br><i>Alan M. Blaker</i> M.D.   |  |  |  |   |  | DEGREE<br><i>M.D.</i>   |  | 22c. DATE SIGNED<br><i>1/3/85</i>  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><i>Alan M. Blaker</i>   |  |  |  |   |  | 22e. ADDRESS<br><i>Mercy Hospital - Balto Md.</i>   |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><i>BURIAL</i>   |  |  | 23b. DATE<br><i>JAN 7, 1985</i>  |   | 23c. NAME OF CEMETERY OR CREMATORY<br><i>PARKWOOD CEMETERY</i> |   | 23d. LOCATION<br>BALTIMORE COUNTY MARYLAND |  |  |
| 24. FUNERAL DIRECTOR<br>NAME<br><i>SOL LEVINSON &amp; BROS., INC.</i><br>ADDRESS<br><i>6010 REISTERSTOWN RD. BALTO., MD 21215</i>  |  |  |  |   |  | 25a. DATE REC'D. BY REGISTRAR<br><i>JAN 11 1985</i>   |  | 25b. REGISTRAR'S SIGNATURE<br><i>John Davidson-Russell</i>   |  |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

WEDNESDAY



WHEATON



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 10 days after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

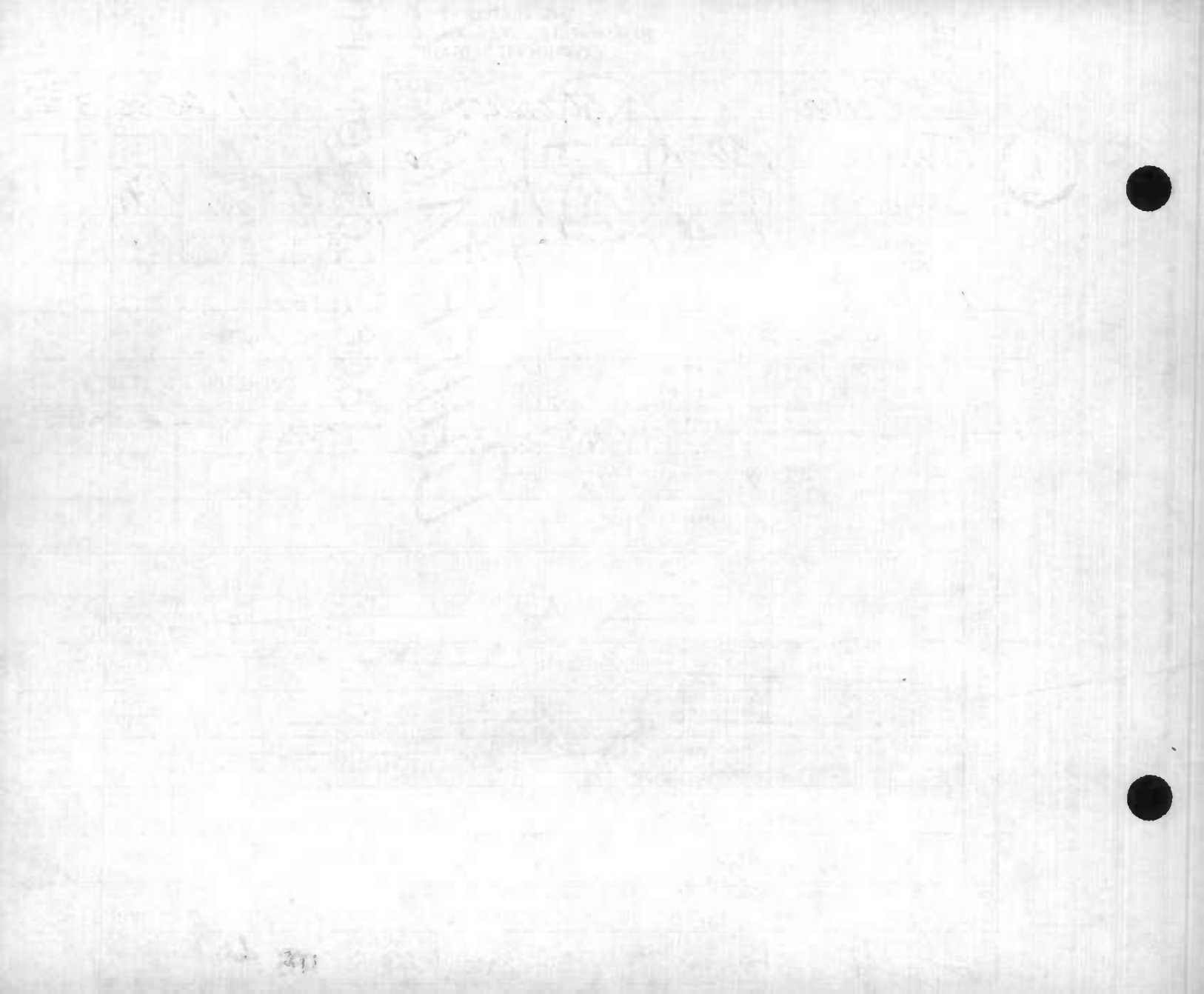
FOR  
STATE  
REGISTRAR

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|   |  |   |   |  |  |  |  |   |  |
|---|--|---|---|--|--|--|--|---|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT) <i>Eula</i>   |  |   | 2a. DATE OF DEATH MONTH DAY YEAR <i>1 25 85</i>                     |  |  | 2b. HOUR <i>3:30</i> M   |  |   |  |
| 3 SEX <i>Female</i>   |  | 4 RACE <i>Black</i>   |   | 5. DATE OF BIRTH MONTH DAY YEAR <i>5 19 10</i>   |  | 6 AGE (IN YEARS LAST BIRTHDAY) <i>74</i> YRS.                                  |  | IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <i>S.C.</i>   |  | 7b. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>  |   | 8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9 BALTIMORE CITY OR COUNTY OF DEATH <i>Baltimore City</i> MD.                  |  |   |  |
| 10 CITY OR TOWN OF DEATH <i>Baltimore</i>   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <i>Hughes Hospital</i> |   |  |  | 12a. USUAL OCCUPATION (TYPE OF BUSINESS) <i>Home Maker</i>                     |  | 12b. KIND OF BUSINESS OR INDUSTRY   |  |
| 13a. STATE <i>MD</i>  |  |   | 13b. COUNTY   |  | 13c. CITY OR TOWN <i>Baltimore</i>                                 |  | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>   |   |  |
| 14 FATHER'S NAME FIRST MIDDLE LAST <i>Asbery Henry</i>  |  |   | 15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <i>Jessie Mae Wonsley</i> |  |  |  |  |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES NO OR UNKNOWN) <i>0</i>   |  |   | 16b. SOCIAL SECURITY NO <i>217-24-2549</i>                          |  | 17 INFORMANT ADDRESS <i>Daisy Spencer, 2206 McCulloh St. 21217</i> |  |  |   |  |
| 18 CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <i>Cardiac Arrest Secondary</i><br>DUE TO, OR AS A CONSEQUENCE OF (b) <i>MI</i><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>DUE TO, OR AS A CONSEQUENCE OF (c)<br>PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: <i>CHF</i> |  |   |   |  |  |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH  |  |
| 19a. DATE OF OPERATION  |  |   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                    |  |  | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>         |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) P.M. <i>19</i>   |  |   | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR                        |  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) |  |   |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK  |  |   | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) |  |  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE                                 |  |   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <i>1/24</i> , 19 <i>85</i> , to <i>1/25</i> , 19 <i>85</i> , that (I) (we) last saw the deceased alive on <i>1/24</i> , 19 <i>85</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.  |  |   |   |  |  |  |  |   |  |
| 22b. SIGNATURE <i>Marie Sam</i> DEGREE <i>MD</i>  |  |   | 22c. DATE SIGNED <i>1/25/85</i>                                     |  |  |  | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) <i>Marie Sam</i>  |  |   | 22e. ADDRESS <i>6017 ANT MATT PINE EC MD 21043</i>                  |  |  |  |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>Burial</i>   |  |   | 23b. DATE <i>1/31/85</i>  |  | 23c. NAME OF CEMETERY OR CREMATORY <i>Arbutus Mem Park</i>         |  | 23d. LOCATION CITY OR TOWN COUNTY STATE <i>Baltimore, Maryland</i>   |   |  |
| 24 FUNERAL DIRECTOR NAME <i>Law Funeral Home</i> ADDRESS <i>4611 Park Heights Ave. 21215</i>  |  |   |   |  | 25a. DATE REC'D. BY REGISTRAR <i>FEB 5 1985</i>                    |  | 25b. REGISTRAR'S SIGNATURE <i>Lula Davidson-Randall</i>  |   |  |

BP



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IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be called on to autopsied.

## MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH  |  |   |   |   |  |   |   |  |  |
|---|--|---|---|---|--|---|---|--|--|
| 1. FOR STATE REGISTRAR  |  |   |   |   | REG. NO.   |   |   |  |  |
| 1. DECEASED NAME (TYPE OR PRINT)<br>FIRST MIDDLE LAST<br>Rose Marie Winkelman   |  |   |   |   | 2a. DATE OF DEATH MONTH DAY YEAR<br>1 25 1985  |   |   | 2b. HOUR<br>1:15 P.M.  |  |
| 3. SEX<br>Female  |  | 4. RACE<br>White  |   | 5. DATE OF BIRTH MONTH DAY YEAR<br>May 3, 1907  |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br>77 YRS.                                      |   | IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS<br>HOURS MIN.  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Maryland   |  | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.A.  |   | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Baltimore City MD.                      |   |  |  |
| 10. CITY OR TOWN OF DEATH<br>Baltimore  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF IN CHURCH, CLERGY, GIVE STREET ADDRESS)<br>5109 Eugene Ave. (Residence) |   |   |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Crossing Guard |   | 12b. KIND OF BUSINESS OR INDUSTRY<br>Balt. City.   |  |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)   |  |   |   |   | 13a. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>  |   |   |  |  |
| 13a. STATE<br>Maryland  |  | 13b. COUNTY   |   | 13c. CITY OR TOWN<br>Baltimore  |  | 13d. STREET ADDRESS<br>5109 Eugene Ave. 21206                                   |   |  |  |
| 14. FATHER'S NAME FIRST MIDDLE LAST<br>Wehner   |  |   |   |   | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST<br>Anna Krebs   |   |   |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)<br>No   |  | 16b. SOCIAL SECURITY NO.<br>218-40-9092   |   | 17. INFORMANT ADDRESS<br>Louis C. Winkelman, Jr. 7810 Aiken Ave. 21234  |  |   |   |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <i>Coronary Heart Failure</i><br>DUE TO, OR AS A CONSEQUENCE OF (b) <i>Hypertensive Cardio-vascular Disease</i><br>DUE TO, OR AS A CONSEQUENCE OF (c) <i>Renal Failure</i><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. |  |   |   |   |  |   |   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><i>3 months</i><br><i>20 yrs</i> |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a) <i>Renal Failure</i>   |  |   |   |   |  |   |   |  |  |
| 19a. DATE OF OPERATION  |  |   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                    |   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>       |   | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)  |  |   | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR<br>P.M. 19             |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)   |   |   |  |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK   |  |   | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) |   | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE   |   |   |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <i>11-24-1983</i> to <i>1-28-1985</i> , that (I) (we) lost saw the deceased alive on <i>12-28-1984</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.  |  |   |   |   |  |   |   |  |  |
| 22b. SIGNATURE <i>Francis T. Daly M.D.</i> DEGREE <i>M.D.</i>   |  |   |   |   | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |   |   | 22c. DATE SIGNED<br><i>1-25-85</i>   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><i>Francis T. Daly M.D.</i>  |  |   |   |   | 22e. ADDRESS<br><i>7401 Oster Drive Towson Md 21204</i>  |   |   |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br>Burial   |  |   | 23b. DATE<br>Jan 28 1985  |   | 23c. NAME OF CEMETERY OR CREMATORY<br>Most Holy Redeemer   |   | 23d. LOCATION CITY OR TOWN COUNTY STATE<br>Baltimore Maryland |  |  |
| 24. FUNERAL DIRECTOR<br>Leonard J. Ruck Inc.  |  |   |   |   | 5305 Harford Rd. 21214   |   | 25. DATE REC'D BY REGISTRAR<br>JAN 28 1985                    |  |  |
| 25b. REGISTRAR'S SIGNATURE  |  |   |   |   |  |   |   |  |  |

BP \_\_\_\_\_

TO : SAC, NEW YORK  
FROM : SAC, BALTIMORE  
SUBJECT: [Illegible]  
RE: [Illegible]  
[Illegible text follows, including names and addresses]

[Large section of illegible text, likely a body of a letter or report]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use at the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1- FOR  
STATE  
REGISTRAR

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|  |  |   |   |   |  |
|--|--|---|---|---|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>Emmett M. WINKS SR.   |  |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br>January 30, 1985                     |   | 2b. HOUR<br>6:40A <sub>M</sub>   |
| 3. SEX<br>M  | 4. RACE<br>WHITE   | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>10-4-1916   |   | 6. AGE (IN YEARS LAST BIRTHDAY)<br>68 YRS.  | IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS.<br>HOURS MIN.   |
| 7a. BIRTHPLACE<br>(STATE OR FOREIGN COUNTRY)<br>MD.  | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.A.   | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Baltimore City MD.                  |   |  |
| 10. CITY OR TOWN OF DEATH<br>Baltimore   | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>Maryland General Hospital |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>RETIRED | 12b. KIND OF BUSINESS OR INDUSTRY<br>MECH.  |  |
| 13a. STATE<br>MD.  |  | 13b. COUNTY   | 13c. CITY OR TOWN<br>BALTO.   | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | 13e. STREET ADDRESS, ZIP CODE<br>711 S. CURLEY ST. 21224   |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>JOHN WINKS   |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>ANNA FARLEY  |   |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br>NO   |  | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br>215 01-6715  | 17. INFORMANT<br>ADDRESS<br>GERALDINE WINKS SAME 21224                      |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) Myocardial Infarction (Heart Failure)<br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) Hypothermia<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c)<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.  |  |   |   |   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH   |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I:<br>Diabetic ketoacidosis, Sepsis; Cerebral Anoxia.  |  |   |   |   |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>            | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)                  |  |
| 21d. INJURY OCCURRED<br>WHERE <input type="checkbox"/> NOT WHERE <input type="checkbox"/><br>AT WORK AT WORK   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |
| 22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from January 7, 1985, to January 30, 1985, that <input checked="" type="checkbox"/> we) lost saw the deceased alive on January 30, 1985, and that in <input checked="" type="checkbox"/> (our) opinion death occurred on the date and hour and from the causes stated above. <input checked="" type="checkbox"/> (we) (did) <input checked="" type="checkbox"/> (did not) view the body after death. |  |   |   |   |  |
| 22b. SIGNATURE<br>Joseph Blustein M.D.   |  | DEGREE<br>M.D.  |   | 22c. DATE SIGNED<br>1/30/85   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>Joseph Blustein, M.D.   |  | 22e. ADDRESS<br>c/o Maryland General Hospital   |   |   |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(CHECK BY)<br>CREMATION   | 23b. DATE<br>2-2-85  | 23c. NAME OF CEMETERY OR CREMATORY<br>WESTVIEW MEM.   |   | 23d. LOCATION<br>CITY OR TOWN<br>BALTO. CO. MD.   | STATE  |
| 24. FUNERAL DIRECTOR<br>HOFFMAN - SKARDA F.H.  |  | ADDRESS<br>3218 HUDSON ST   |   | 25a. DATE REC'D. BY REGISTRAR<br>FEB 5 1985   | 25b. REGISTRAR'S SIGNATURE<br>G. Davidson-Randall  |

BP 20



*[Faint, mostly illegible handwritten text, possibly a list or notes.]*

UNITED STATES  
DEPARTMENT OF AGRICULTURE  
BUREAU OF PLANT INDUSTRY



*[Small handwritten mark or signature in the bottom right corner.]*



STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 5

0 1

7 2 0

FOR  
1. STATE  
REGISTRAR

REG. NO.

|  |  |   |  |  |   |   |  |  |  |  |  |
|--|--|---|--|--|---|---|--|--|--|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>RITA L. WINNER  |  |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br>JANUARY 15, 1985                |  |   | 2b. HOUR<br>5:52 A M  |  |  |  |  |  |
| 3 SEX<br>FEMALE  |  | 4. RACE<br>WHITE  |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>OCT. 5, 1919   |   | 6. AGE (IN YEARS LAST BIRTHDAY)<br>65 YRS.  |  | 7. IF UNDER 1 YEAR<br>MONTHS DAYS HOURS MIN.   |  |  |  |
| 8. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>MARYLAND   |  | 9. CITIZEN OF WHAT COUNTRY?<br>USA  |  | 10. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 11. BALTIMORE CITY OR COUNTY OF DEATH<br>BALTIMORE CITY MD                                      |  |  |  |  |  |
| 12. CITY OR TOWN OF DEATH<br>BALTIMORE   |  | 13. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>JOHNS HOPKINS HOSPITAL |  |  |   | 14. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>HOUSEWIFE                    |  | 15. KIND OF BUSINESS OR INDUSTRY<br>AT HOME  |  |  |  |
| 16. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE COUNTY<br>MARYLAND BALTO.  |  |   |  | 13b. CITY OR TOWN<br>BALTIMORE   |   | 13c. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  | 13d. STREET ADDRESS / ZIP CODE<br>1 SLADE AVE., APT. 506 #21208  |  |  |  |
| 17. FATHER'S NAME<br>FIRST MIDDLE LAST<br>MORTON ROSENBERG   |  |   |  | 18. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>MAYME SNEIDMAN  |   |   |  |  |  |  |  |
| 19a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)<br>NO   |  |   |  | 19b. SOCIAL SECURITY NO.<br>215-18-5242  |   | 20. INFORMANT<br>MR. FREDERICK P. WINNER<br>1 SLADE AVE., APT. 506 #21208                       |  |  |  |  |  |
| 21. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Sepsis</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <u>Carcinoma of lung</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <u>capillary carcinoma of bladder, distal to the lymphatic</u><br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><u>48 hours</u><br><u>1 1/2 years</u> |  |   |  |  |   |   |  |  |  |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)<br><u>capillary carcinoma of bladder, distal to the lymphatic</u>  |  |   |  |  |   |   |  |  |  |  |  |
| 22a. DATE OF OPERATION   |  |   | 22b. CONDITION FOR WHICH OPERATION WAS PERFORMED                       |  |   | 22c. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>            |  | 22d. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |  |  |
| 23a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  |   | 23b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19             |  |   | 23c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)                  |  |  |  |  |  |
| 24a. INJURY OCCURRED<br>WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK  |  |   | 24b. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) |  |   | 24c. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |  |  |  |  |
| 25. I certify that (I) (this hospital) attended the deceased from <u>1/10</u> 19 <u>85</u> , to <u>1/15</u> 19 <u>85</u> , that (I) (we) last saw the deceased alive on <u>1/15</u> 19 <u>85</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.  |  |   |  |  |   |   |  |  |  |  |  |
| 26. SIGNATURE<br><u>Michele F. Nowatarsky</u> DEGREE<br>ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>   |  |   |  |  |   | 27. DATE SIGNED<br><u>1-15-85</u>   |  |  |  |  |  |
| 28. PHYSICIAN'S NAME (TYPE OR PRINT)<br><u>Michele F. Nowatarsky</u>   |  |   |  |  |   | 29. ADDRESS<br><u>600 N. Wilt St. Baltim, MD 21205</u>  |  |  |  |  |  |
| 30a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br>BURIAL   |  |   | 30b. DATE<br>JAN. 16, 1985   |  | 30c. NAME OF CEMETERY OR CREMATORY<br>OHEB SHALOM MEM. PARK |   |  | 30d. LOCATION<br>REISTERSTOWN BALTO. MD  |  |  |  |
| 31. FUNERAL DIRECTOR<br>NAME SOL LEVINSON & BROS., INC.<br>ADDRESS<br>6010 REISTERSTOWN RD. BALTO., MD 21215   |  |   |  |  |   | 32. DATE REC'D. BY REGISTRAR<br>JAN 17 1985   |  | 33. REGISTRAR'S SIGNATURE<br><u>John Davidson-Wendell</u>  |  |  |  |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be returned by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial transit permit. Then please remove carbon pages. Pages 1 and 2 must be filed with the health department within 24 hours of death.

TO THE STATE DEPT. OF HEALTH AND MENTAL HYGIENE: This certificate must be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked as item 18, does any injury, or other traumatic event, then the death certificate must be filed with the State Dept. of Health and Mental Hygiene within 24 hours of death.



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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 1 and 2 should be detached for use as the burial/transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE  |  |   |  | 8-5 01721  |  |
|---|--|---|--|--|--|
| 1- STATE REGISTRAR  |  |   |  | REG. NO.   |  |
| 1 DECEASED NAME<br>(TYPE OR PRINT)<br>FIRST MIDDLE LAST<br>CHARLES C. WINSTON   |  |   |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br>January 28, 1985                              |  |
| 3. SEX<br>Male  |  | 4. RACE<br>White  |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>Mar. 28, 1908                                  |  |
| 7a. BIRTHPLACE<br>(STATE OR FOREIGN COUNTRY)<br>N.J.  |  | 7b. CITIZEN OF WHAT COUNTRY?<br>USA   |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br>70 YRS. 75 MONTHS DAYS HOURS MIN.                 |  |
| 10. CITY OR TOWN OF DEATH<br>Baltimore  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>335 Homeland Southway (2A) |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Baltimore City MD.                           |  |
| 13a. STATE<br>MD  |  | 13b. COUNTY   |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Civil Engineer   |  |
| 13c. CITY OR TOWN<br>Baltimore  |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>   |  | 12b. KIND OF BUSINESS OR INDUSTRY<br>Sherwood  |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>Charles A. Winston  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Katherine McNitt   |  | 13e. STREET ADDRESS / ZIP CODE<br>Forest Club<br>335 Homeland Southway 21212         |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br>No  |  | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br>142 01 4868  |  | 17. INFORMANT<br>ADDRESS<br>Ivins & Taylor Funeral Home, NJ                          |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for 1a, 1b, and 1c.)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Cancer of bowel</u><br>DUE TO, OR AS A CONSEQUENCE OF (b) <u>with metastases</u><br>DUE TO, OR AS A CONSEQUENCE OF (c) <u>1 Year</u> |  |   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br>1 Year                               |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a  |  |   |  |  |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |
| 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>  |  |   |  |  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)       |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)<br>1976  |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE<br>1/28 1985                       |  |
| 22a. I certify that (I) (this hospital) attested the deceased from above, (I) (we) (we) (we) view the body after death, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated   |  |   |  |  |  |
| 22b. SIGNATURE<br>Dr. William G. Helfrich, MD   |  | 22c. DATE SIGNED<br>1/28/85   |  | 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>Dr. William G. Helfrich, MD                 |  |
| 22e. ADDRESS<br>5006 Roland Avenue, Balto., MD  |  |   |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br>Cremation   |  | 23b. DATE<br>1/29/85  |  | 23c. NAME OF CEMETERY OR CREMATORY<br>Green Mount                                    |  |
| 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Balto., MD  |  |   |  |  |  |
| 24. FUNERAL DIRECTOR<br>NAME<br>Henry W. Jenkins & Sons Co.<br>4905 York Road Balto., MD 21212  |  | 25a. DATE REC'D. BY REGISTRAR<br>JAN 29 1985  |  | 25b. REGISTRAR'S SIGNATURE<br>[Signature]  |  |

BP

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STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 5 0 1 7 2 2

1. FOR  
STATE  
REGISTRAR

REG. NO.

|  |  |   |  |   |   |   |   |   |  |   |  |
|--|--|---|--|---|---|---|---|---|--|---|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>FIRST MIDDLE LAST<br><b>Geneva M. WISE</b>  |  |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>January 8, 1985</b>                          |   | 2b. HOUR<br><b>4:55A</b>  |   |   |   |  |   |  |
| 3. SEX<br><b>FEMALE</b>  |  | 4. RACE<br><b>BLACK</b>   |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>5 - 31-02</b>  |   | 6. AGE (IN YEARS LAST BIRTHDAY)<br>YRS.<br><b>82</b>  |   | IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS<br>HOURS MIN.   |  |   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>MARYLAND</b>   |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>  |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore City</b> MD.   |   |   |  |   |  |
| 10. CITY OR TOWN OF DEATH<br><b>Baltimore</b>  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Maryland General Hospital</b> |  |   |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)  |   | 12b. KIND OF BUSINESS OR INDUSTRY   |  |   |  |
| 13a. STATE<br><b>Md.</b>   |  |   | 13b. COUNTY<br><b>BALTO</b>  |   | 13c. CITY OR TOWN<br><b>BALTO</b>                                   |   | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |   | 13e. STREET ADDRESS / ZIP CODE<br><b>821 CHAUNCEY AVE. 21217</b> |   |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>MATTHEW WILLIAMS</b>  |  |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>CLARA GARRETT</b>                  |   |   |   |   |   |  |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>NO</b>  |  |   | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br><b>220-18-4722</b>          |   | 17. INFORMANT<br>ADDRESS<br><b>TERRY WILSON 529 PENNY LA. 21030</b> |   |   |   |  |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Cardiopulmonary arrest</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <u>Respiratory failure</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <u>Pneumonectomy for carcinoma of the lung (right)</u><br>PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a):<br><u>Hypoxic Encephalopathy</u>  |  |   |  |   |   |   |   |   |  | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH |  |
| MEDICAL CERTIFICATION  |  |   |  |   |   |   |   |   |  |   |  |
| 19a. DATE OF OPERATION<br><b>November 19, 84</b>   |  |   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED<br><b>Carcinoma of the right LUNG</b> |   |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |   | 20b. IF YES, WERE FINDINGS USED<br>IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |   |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  |   | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>                      |   |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)   |   |   |  |   |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK   |  |   | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                 |   |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |   |   |  |   |  |
| 22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <u>November 12</u> , 19 <u>84</u> , to <u>January 8</u> , 19 <u>85</u> , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on <u>November 8</u> , 19 <u>85</u> , and that in <input checked="" type="checkbox"/> (our) opinion death occurred on the date and hour and from the causes stated above. <input type="checkbox"/> (we) <input type="checkbox"/> (did) <input type="checkbox"/> (did not) view the body after death. |  |   |  |   |   |   |   |   |  |   |  |
| 22b. SIGNATURE<br><i>Debra A. Vachon</i> DEGREE  |  |   |  |   |   | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |   |   | 22c. DATE SIGNED   |   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>Debra A. Vachon, M.D.</b>  |  |   |  |   |   | 22e. ADDRESS<br><b>c/o Maryland General Hospital</b>  |   |   |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>BURIAL</b>  |  |   | 23b. DATE<br><b>1/12/85</b>  |   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>CEDAR HILL CEM.</b>        |   |   | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>BALTO. MD.</b>   |  |   |  |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>LEROY O. DYETT 4600 LIBERTY HGTS. AVE.</b>  |  |   |  |   |   | 25a. DATE REG'D BY REGISTRAR<br><b>JAN 10 1985</b>  |   |   | 25b. REGISTRAR'S SIGNATURE<br><i>[Signature]</i>                 |   |  |

BP 23

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon-copy pages 1 and 2. Page 1 should be filed within 7 days of death in the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.



1100 FBES

UNIT



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. It may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon copies. Page 1 and 2 should be held within 12 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE  |  |  |  | 8 5 0 1 7 2 3   |  |
|---|--|--|--|---|--|
| 1 - FOR STATE REGISTRAR   |  |  |  | CERTIFICATE OF DEATH  |  |
| I. DECEASED NAME (TYPE OR PRINT)  |  |  |  | REG. NO.  |  |
| FIRST MIDDLE LAST<br><b>ILLINOIS WISE</b>   |  |  |  | 2a. DATE OF DEATH MONTH DAY YEAR<br><b>1 20 85</b>  |  |
| 3. SEX<br><b>FEMALE</b>   |  | 4. RACE<br><b>BLACK</b>  |  | 5. DATE OF BIRTH MONTH DAY YEAR<br><b>AUG. 24 1900</b>  |  |
| 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>84</b>  |  | 7. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>  |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  |
| 9a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>SOUTH CAR.</b>  |  | 9b. BALTIMORE CITY OR COUNTY OF DEATH<br><b>BALTIMORE</b>                        |  | 9c. BALTIMORE CITY OR COUNTY OF DEATH<br><b>BALTIMORE</b>   |  |
| 10. CITY OR TOWN OF DEATH<br><b>BALTO.</b>  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br><b>MERCY HOSPITAL</b> |  | 12. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)  |  |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br><b>MD.</b>  |  | 13b. COUNTY<br><b>BALTO.</b>   |  | 13c. INSIDE CITY LIMITS?<br><b>XX</b> YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>   |  |
| 14. FATHER'S NAME FIRST MIDDLE LAST   |  | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST<br><b>LULA WISE</b>                   |  | 16. SOCIAL SECURITY NO.<br><b>214-24-2897</b>   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)<br><b>NO</b>  |  | 16b. SOCIAL SECURITY NO.<br><b>214-24-2897</b>                                   |  | 17. INFORMANT ADDRESS<br><b>JENNIE BAILEY 716 RESERVOIR ST.</b>   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1: DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Cardiac arrhythmias</b><br>DUE TO, OR AS A CONSEQUENCE OF (b) <b>ASCVD</b><br>DUE TO, OR AS A CONSEQUENCE OF (c) <b>Diabetes mellitus</b>   |  |  |  |   |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)   |  |  |  |   |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                                 |  | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR<br><b>11 85 19</b>                  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18: PART 1 OR PART 2)  |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>  |  | 21e. PLACE OF INJURY (AT HOME STREET, FACTORY, OFFICE, FARM, ETC.)               |  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE  |  |
| 22. I certify that (I) (this hospital) attended the deceased from <b>11 85 19</b> to <b>19 84</b> , that (I) (we) last saw the deceased alive on <b>11 85 19</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. |  |  |  |   |  |
| 22b. SIGNATURE<br><b>Ray Brodie Jr. MD</b>  |  | 22c. DEGREE<br><b>MD</b>   |  | 22d. DATE SIGNED<br><b>1/21/85</b>  |  |
| 22e. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>Dr. Ray Brodie Jr.</b>  |  | 22f. ADDRESS<br><b>844 N. CAVEY ST.</b>  |  | 22g. CITY OR TOWN<br><b>LAUREL MD.</b>  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>BURIAL</b>  |  | 23b. DATE<br><b>1/24/85</b>  |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>MARYLAND NAT. PK.</b>  |  |
| 24. FUNERAL DIRECTOR NAME<br><b>LEROY O. DYETT F.H.</b>   |  | 24b. ADDRESS<br><b>4600 LIBERTY H.</b>   |  | 24c. DATE REC'D. BY REGISTRAR<br><b>1 JAN 28 1985</b>   |  |
| 24d. REGISTRAR'S SIGNATURE<br><b>Sasha Davidson-Randall</b>   |  |  |  |   |  |

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FOR F#601  
STATE REGISTRAR

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

|  |                         |   |   |   |   |
|--|-------------------------|---|---|---|---|
| 1. DECEASED NAME<br>(TYPE OR PRINT) FIRST MIDDLE LAST<br><b>ROBERT WISE</b>  |                         |   | 2a. DATE KNOWN OF DEATH<br>ESTIMATED <input checked="" type="checkbox"/> MONTH DAY YEAR<br><b>1-25-85</b> |   | 2b. HOUR<br>M<br><b>11:40</b>   |
| 3. SEX<br><b>M.</b>  | 4. RACE<br><b>NEGRO</b> | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>3 10 55</b>              | 6. AGE (IN YEARS)<br>LAST BIRTHDAY MONTHS DAYS HOURS MIN<br><b>29 YRS.</b>                                | 7c. DATE PRONOUNCED DEAD<br>MONTH DAY YEAR<br><b>1-25-85</b>  | 7d. HOUR<br>M<br><b>11:40</b>   |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Md</b>   |                         | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A</b>                      |   | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |   |
| 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore City</b>  |                         | 10. CITY OR TOWN OF DEATH<br><b>Baltimore</b>                     |   |   |   |
| 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>2612 W. Coldspring Lane</b>   |                         |   | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)   |   | 12b. KIND OF BUSINESS OR INDUSTRY   |
| 13a. STATE<br><b>Md</b>  | 13b. COUNTY             | 13c. CITY OR TOWN<br><b>BALTO</b>                                 | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>           | 13e. STREET ADDRESS<br><b>21215 2612 W. Coldspring Lane</b>   |   |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Ramsey Wise</b>   |                         |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Nannie Woodard</b>                                    |   |   |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO, OR UNKNOWN)<br><b>NO</b>   |                         | 16b. SOCIAL SECURITY NO.<br><b>212 707044</b>                     |   | 17. INFORMANT<br>ADDRESS<br><b>NANNIE B. WISE 4378 Park Heights Ave</b>   |   |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1 DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Seizure disorder &amp; fatty liver</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____   |                         |   |   |   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).  |                         |   |   |   |   |
| 19a. DATE OF OPERATION   |                         | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?                 |   |   | 20. AUTOPSY?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH  |                         | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b> | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)                             |   |   |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>   |                         | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)       | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |   |   |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> . |                         |   |   |   |   |
| ACTUAL SIGNATURE<br><b>Margie One Jones</b>  |                         | TITLE (SPECIFY)<br><b>Assistant</b>                               |   | DATE SIGNED<br><b>1-26-85</b>   |   |
| EXAMINER'S NAME<br>(TYPE OR PRINT)<br><b>Margarita A. Korell, M.D.</b>   |                         | ADDRESS<br><b>111 Penn Street</b>                                 |   |   |   |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>Burial</b>  |                         | 23b. DATE<br><b>2/2/85</b>  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Mt. Calvary</b>  |   | 23d. LOCATION<br>(FOR TOWN)<br><b>U.S. County</b> STATE<br><b>Md</b>                |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>Locks FUNERAL HOME</b>  |                         | ADDRESS<br><b>1304 N. Central Ave</b>                             |   | 25a. DATE REC'D. BY REGISTRAR<br><b>FEB 4 1985</b>  | 25b. REGISTRAR'S SIGNATURE<br><b>[Signature]</b>                                    |

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF, MEDICAL EXAMINER, ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND. 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

MEDICAL CERTIFICATION

421716 NOTED 803

DMC MARK FINE



STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

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0 1 7 2 5

1. FOR  
STATE  
REGISTRAR

REG. NO.

|  |  |   |  |   |  |   |  |  |  |
|--|--|---|--|---|--|---|--|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br><b>Josephine M. Woerner</b>   |  |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>January 14, 1985</b> |   |  | 2b. HOUR<br><b>12 PM</b>  |  |  |  |
| 3. SEX<br><b>Female</b>  |  | 4. RACE<br><b>White</b>   |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>2 8 1904</b>   |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>80</b> YRS.   |  | IF UNDER 1 YEAR<br>MONTHS DAYS HOURS MIN.  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Louisiana</b>  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore City</b> MD.                               |  |  |  |
| 10. CITY OR TOWN OF DEATH<br><b>Baltimore</b>  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Union Memorial Hospital</b> |  |   |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Housewife</b>            |  | 12b. KIND OF BUSINESS OR INDUSTRY  |  |
| 13a. STATE<br><b>Md.</b>   |  | 13b. COUNTY   |  | 13c. CITY OR TOWN<br><b>Baltimore</b>   |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 13e. STREET ADDRESS / ZIP CODE<br><b>5813 The Alameda 21239</b>  |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Anthony Ciaccio</b>   |  |   |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Giovanna Goncashe</b>   |  |   |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>no</b>  |  | 16b. SOCIAL SECURITY NO<br><b>213-74-4552</b>   |  | 17. INFORMANT<br>ADDRESS<br><b>Raymond J. Woerner 8924 Allenswood Rd. 21133</b>   |  |   |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), or (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Death Heart Failure</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last<br>(b) <b>ASTHMATIC BRONCHITIS</b> <b>20 yrs</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <b>Chronic Obstructive Pulmonary Disease</b> <b>20+ yrs</b><br>PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a) |  |   |  |   |  |   |  |  |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  |   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>                       |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |  |   |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |   |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>10-16-1970</b> to <b>1-14-1985</b> , that (I) (we) last saw the deceased alive on <b>1-11-1985</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.  |  |   |  |   |  |   |  |  |  |
| 22b. SIGNATURE<br><b>Francis T. Daly</b>   |  | DEGREE<br><b>MD</b>   |  | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>                  |  |   |  | 22c. DATE SIGNED<br><b>1-15-85</b>   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>Francis T. Daly MD</b>   |  |   |  | 22e. ADDRESS<br><b>7401 Osler Drive Towson, Maryland</b>  |  |   |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>Burial</b>   |  | 23b. DATE<br><b>1-17-85</b>   |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Meadowridge</b>  |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Baltimore Md.</b>                              |  |  |  |
| 24. FUNERAL DIRECTOR<br>NAME ADDRESS<br><b>Leonard J. Ruck Inc. Baltimore, Maryland</b>  |  |   |  | 25a. DATE REC'D. BY REGISTRAR<br><b>JAN 16 1985</b>   |  | 25b. REGISTRAR'S SIGNATURE<br><b>Lelia Davidson-Randall</b>                                     |  |  |  |

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MEDICAL CERTIFICATIONTO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 3 and 4 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.  
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of cause.

BP



STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 5 0 1 7 2 6

| FOR STATE REGISTRAR  |  |  |  | REG. NO.  |  |  |  |
|--|--|--|--|---|--|--|--|
| 1. DECEASED NAME (TYPE OR PRINT)   |  |  |  | 2a. DATE OF DEATH   |  |  |  |
| FIRST MIDDLE LAST<br>Alfred Wolfe  |  |  |  | MONTH DAY YEAR<br>1 15 85   |  |  |  |
| 3. SEX   |  |  |  | 2b. HOUR  |  |  |  |
| Male   |  |  |  | 4:30 A.M.   |  |  |  |
| 4. RACE  |  | 5. DATE OF BIRTH   |  | 6. AGE (IN YEARS LAST BIRTHDAY)   |  | IF UNDER 1 YEAR  |  |
| WHITE  |  | MONTH DAY YEAR<br>12 04 04   |  | 80  |  | IF UNDER 24 HRS  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)  |  | 7b. CITIZEN OF WHAT COUNTRY?   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>  |  | 9. BALTIMORE CITY OR COUNTY OF DEATH   |  |
| GERMANY  |  | U.S.A.   |  | Balt. City  |  | MD.  |  |
| 10. CITY OR TOWN OF DEATH  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)   |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)   |  | 12b. KIND OF BUSINESS OR INDUSTRY  |  |
| BALTIMORE  |  | SINAI HOSPITAL   |  | SALESMAN  |  | INSTALLMENTS   |  |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) |  | 13b. CITY  |  | 13c. INSIDE CITY LIMITS?  |  | 13d. STREET ADDRESS  |  |
| MARYLAND   |  | BALTO.   |  | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  | APT. A-3 #21208  |  |
| 14. FATHER'S NAME  |  | 15. MOTHER'S MAIDEN NAME   |  | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (NO OR UNKNOWN)  |  | 16b. SOCIAL SECURITY NO.   |  |
| FIRST MIDDLE LAST<br>LEOPOLD WOLF  |  | FIRST MIDDLE LAST<br>ROSA UNKNOWN  |  | NO  |  | 056141440  |  |
| 17. INFORMANT  |  | 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)  |  | 19. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  |
| MRS. RONA A. WEINER  |  | PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>cardiopulmonary arrest</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <u>cancer colon &amp; metastasis</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>   |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>   |  |
| 11012 VALLEY HEIGHTS DR. OWINGS MILLS, MD  |  | PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)   |  | 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19   |  |
| 21117  |  |  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |  | 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  |  |
|  |  |  |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE  |  |
|  |  |  |  | 22a. I certify that (I) (this hospital) attended the deceased from <u>Dec. 12</u> , 19 <u>84</u> , to <u>Jan 15</u> , 19 <u>85</u> , that (I) (we) last saw the deceased alive on <u>Jan 15</u> , 19 <u>85</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |  | 22b. SIGNATURE<br><u>Clayton M. Berger M.D.</u> DEGREE<br>ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> |  |
|  |  |  |  | 22c. DATE SIGNED<br><u>1/15/84</u>  |  | 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><u>Clayton Berger M.D.</u>  |  |
|  |  |  |  | 22e. ADDRESS<br><u>Smal Hosp. of Balt.</u>  |  | 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL   |  |
|  |  |  |  | 23b. DATE<br><u>JAN. 16, 1985</u>   |  | 23c. NAME OF CEMETERY OR CREMATORY<br><u>CHEVRA AHAVAS CHESD</u>   |  |
|  |  |  |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><u>RANDALLSTOWN BALTO. MD</u>   |  | 24. FUNERAL DIRECTOR<br>NAME ADDRESS<br><u>SOL LEVINSON &amp; BROS., INC.</u><br><u>6010 REISTERSTOWN RD. BALTO., MD 21215</u>   |  |
|  |  |  |  | 25a. DATE REC'D. BY REGISTRAR<br><u>JAN 17 1985</u>   |  | 25b. REGISTRAR'S SIGNATURE<br><u>[Signature]</u>   |  |

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use on the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked by item 18 above as injury, or other traumatic event, the medical examiner must be notified at once.

BP





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers, Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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1- FOR  
STATE  
REGISTRAR

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

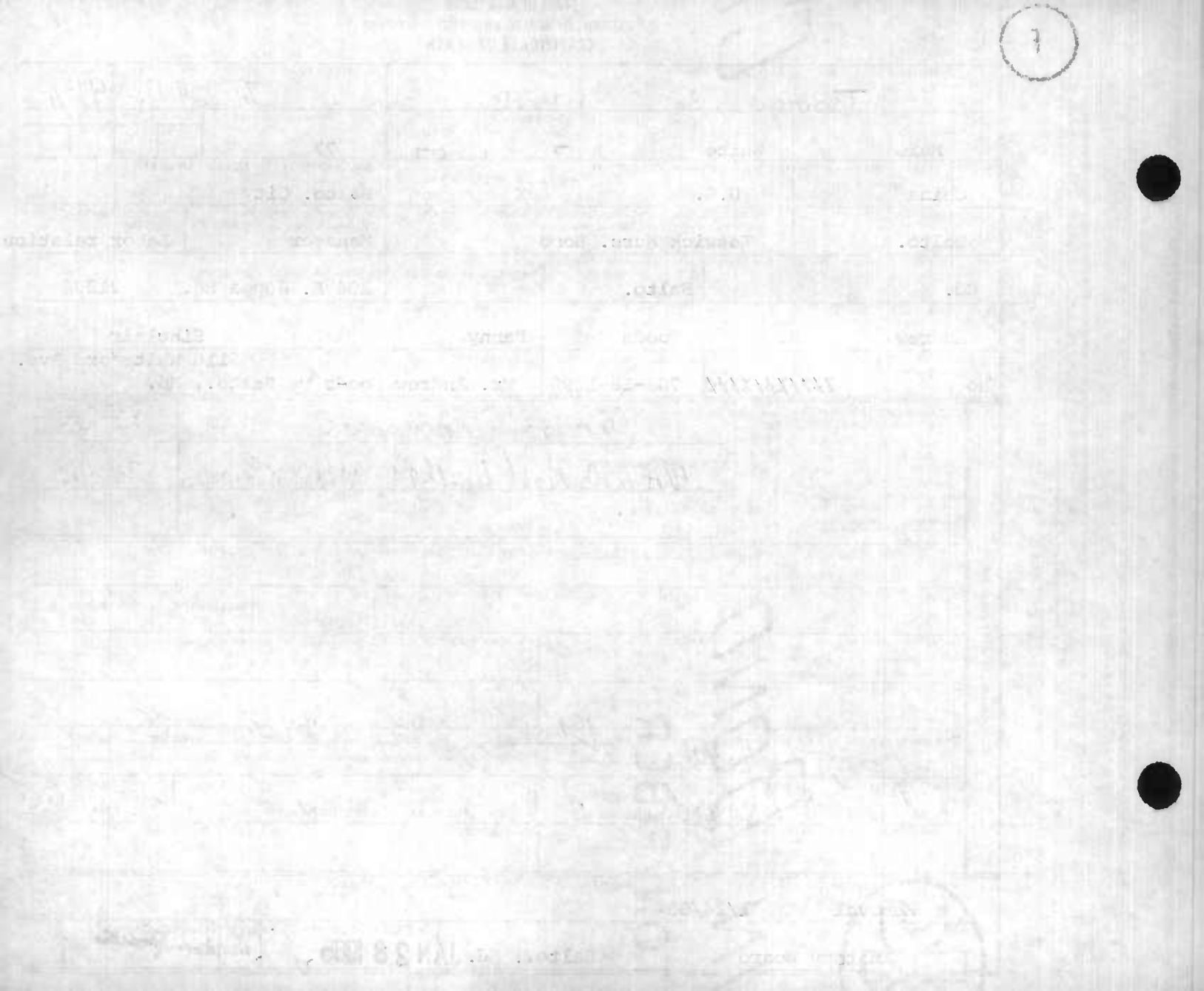
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REG. NO.

|  |  |   |  |  |                                    |  |   |  |  |   |  |
|--|--|---|--|--|------------------------------------|--|---|--|--|---|--|
| 1 DECEASED NAME<br>(TYPE OR PRINT)<br>Thomas S. Woods  |  |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br>JAN 24 1985                     |  |                                    | 2b. HOUR<br>9:15 A.M.  |   |  |  |   |  |
| 3 SEX<br>Male  |  | 4 RACE<br>White   |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>7 11 07  |                                    | 6. AGE (IN YEARS LAST BIRTHDAY)<br>77 YRS.                                     |   | 7. UNDER 1 YEAR<br>MONTHS DAYS   |  | 8. UNDER 24 HRS.<br>HOURS MIN.                                    |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>China   |  | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.  |  | 8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |                                    | 9 BALTIMORE CITY OR COUNTY OF DEATH<br>Balto. City MD.                         |   |  |  |   |  |
| 10 CITY OR TOWN OF DEATH<br>Balto.   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>Keswick Nurs. Home |  |  |                                    | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Manager    |   |  | 12b. KIND OF BUSINESS OR INDUSTRY<br>Labor relations   |   |  |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE<br>Md.  |  |   | 13b. COUNTY<br>BALTO.  |  | 13c. CITY OR TOWN<br>Balto.        |  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  | 13e. STREET ADDRESS / ZIP CODE<br>204 E. Joppa Rd. 21204   |   |  |
| 14 FATHER'S NAME<br>FIRST MIDDLE LAST<br>Andrew H. Woods   |  |   |  | 15 MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Fanny Sinclair   |                                    |  |   |  |  |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br>No   |  | (IF YES, GIVE WAR OR DATES)<br>708-18-1290  |  | 16b. SOCIAL SECURITY NO.<br>708-18-1290  |                                    | 17 INFORMANT<br>Mr. Andrew Woods   |   |  | ADDRESS 5116 Whiteford Ave. Balto., Md.  |   |  |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) Cerebral Thrombosis<br>DUE TO, OR AS A CONSEQUENCE OF (b) CVA with Right Hemiplegia, aphasia & Seizures<br>DUE TO, OR AS A CONSEQUENCE OF (c)<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. |  |   |  |  |                                    |  |   |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br>16 HRS<br>24 YRS. |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a.  |  |   |  |  |                                    |  |   |  |  |   |  |
| 19a. DATE OF OPERATION   |  |   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                       |  |                                    |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>                       |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |   |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  |   | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19             |  |                                    | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) |   |  |  |   |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK   |  |   | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) |  |                                    | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                              |   |  |  |   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from 18 JAN 85 to 24 JAN 85, that (II) (we) last saw the deceased alive on 24 JAN 85, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.   |  |   |  |  |                                    |  |   |  |  |   |  |
| 22b. SIGNATURE<br>C. Richardson M.D.   |  |   |  |  |                                    | DEGREE   |   | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input checked="" type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |  | 22c. DATE SIGNED<br>24 JAN 1985                                   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)  |  |   |  |  |                                    | 22e. ADDRESS   |   |  |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br>Removal  |  |   | 23b. DATE<br>1/24/85   |  | 23c. NAME OF CEMETERY OR CREMATORY |  |   | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE   |  |   |  |
| 24. FUNERAL DIRECTOR<br>NAME<br>Anatomy Board  |  |   |  |  |                                    | ADDRESS<br>Balto., Md.   |   | 25a. DATE REC'D. BY REGISTRAR<br>JAN 28 1985   |  | 25b. REGISTRAR'S SIGNATURE<br>Julia Davidson-Randall              |  |

BP





STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

|  |         |   |  |   |  |   |  |  |  |   |  |       |  |      |  |           |  |
|--|---------|---|--|---|--|---|--|--|--|---|--|-------|--|------|--|-----------|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)  |         | FIRST   |  | MIDDLE  |  | LAST  |  | 2a. DATE KNOWN OF DEATH                      |  | MONTH   |  | DAY   |  | YEAR |  | 2b. HOUR  |  |
| Ida Mae Wright   |         |   |  |   |  |   |  | 1-24   |  | 19  |  | 85    |  |      |  |           |  |
| 3. SEX   | 4. RACE | 5. DATE OF BIRTH  |  | 6. AGE (IN YEARS)   |  | IF UNDER 1 YR.  |  | IF UNDER 24 HRS.                             |  | 7c. DATE PRONOUNCED DEAD  |  | MONTH |  | DAY  |  | YEAR      |  |
| female   | black   | 12 27 44  |  | 40 YRS.   |  |   |  |  |  | 1-24  |  | 19    |  | 85   |  | 1:50 a.m. |  |
| 7b. BIRTHPLACE (STATE OR FOREIGN COUNTRY)  |         | 7b. CITIZEN OF WHAT COUNTRY?                                |  | 8. MARRIED  |  | NEVER MARRIED   |  | 9. BALTIMORE CITY OR COUNTY OF DEATH         |  |   |  |       |  |      |  |           |  |
| Maryland   |         | U.S.A.  |  | WIDOWED   |  | DIVORCED  |  | Baltimore City,                              |  |   |  |       |  |      |  |           |  |
| 10. CITY OR TOWN OF DEATH  |         | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION    |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)                 |  | 12b. KIND OF BUSINESS OR INDUSTRY                                   |  |  |  |   |  |       |  |      |  |           |  |
| Baltimore  |         | Bon Secours Hospital  |  |   |  |   |  |  |  |   |  |       |  |      |  |           |  |
| 13a. STATE   |         | 13b. COUNTY   |  | 13c. CITY OR TOWN   |  | 13d. INSIDE CITY LIMITS?  |  | 13e. STREET ADDRESS                          |  |   |  |       |  |      |  |           |  |
| Maryland   |         |   |  | Baltimore   |  | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 1228 E. Eager St. 21202                      |  |   |  |       |  |      |  |           |  |
| 14. FATHER'S NAME  |         | 15. MOTHER'S MAIDEN NAME                                    |  |   |  |   |  |  |  |   |  |       |  |      |  |           |  |
| Willie Robertson   |         | Dorothy Betared   |  |   |  |   |  |  |  |   |  |       |  |      |  |           |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)   |         | 16b. SOCIAL SECURITY NO.                                    |  | 17. INFORMANT   |  | ADDRESS   |  |  |  |   |  |       |  |      |  |           |  |
| NO   |         | 214-44-1397   |  | Donald Wright   |  | 2036 W. Baltimore St.   |  |  |  |   |  |       |  |      |  |           |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)  |         | PART 1 DEATH WAS CAUSED BY:                                 |  | IMMEDIATE CAUSE (a)   |  | Acute Myocardial Infarct  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |  |   |  |       |  |      |  |           |  |
|  |         |   |  | (b)   |  | Arteriosclerotic Cardiovascular Disease                             |  |  |  |   |  |       |  |      |  |           |  |
|  |         |   |  | (c)   |  |   |  |  |  |   |  |       |  |      |  |           |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1   |         | Diabetes Mellitus   |  |   |  |   |  |  |  |   |  |       |  |      |  |           |  |
| 19a. DATE OF OPERATION   |         | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?           |  |   |  |   |  | 20. AUTOPSY? (Chest Only)                    |  | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |       |  |      |  |           |  |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH  |         | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19        |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) |  |   |  |  |  |   |  |       |  |      |  |           |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>   |         | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) |  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE                                |  |   |  |  |  |   |  |       |  |      |  |           |  |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> . Inspection <input type="checkbox"/> . Inquiry <input type="checkbox"/> . and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> . |         |   |  |   |  |   |  |  |  |   |  |       |  |      |  |           |  |
| ACTUAL SIGNATURE   |         | TITLE (SPECIFY)   |  | DATE SIGNED   |  |   |  |  |  |   |  |       |  |      |  |           |  |
| Dennis F. Smyth, M.D.  |         | Assistant   |  | 1-24-85   |  |   |  |  |  |   |  |       |  |      |  |           |  |
| EXAMINER'S NAME (TYPE OR PRINT)  |         | ADDRESS   |  |   |  |   |  |  |  |   |  |       |  |      |  |           |  |
| Dennis F. Smyth, M.D.  |         | 111 Penn St., Balto., Md. 21201                             |  |   |  |   |  |  |  |   |  |       |  |      |  |           |  |
| 23a. BURIAL, CREMATION, REMOVAL  |         | 23b. DATE   |  | 23c. NAME OF CEMETERY OR CREMATORY  |  | 23d. LOCATION CITY OR TOWN COUNTY MD.                               |  |  |  |   |  |       |  |      |  |           |  |
| BURIAL   |         | 1/29/85   |  | Mount Auburn Cem.   |  | Baltimore, Md.  |  |  |  |   |  |       |  |      |  |           |  |
| 24. FUNERAL DIRECTOR NAME  |         | ADDRESS   |  | 25a. DATE REC'D BY REGISTRAR  |  | 25b. REGISTRAR'S SIGNATURE  |  |  |  |   |  |       |  |      |  |           |  |
| Wm C March F/H Inc.  |         | 1101 E North Avenue   |  | JAN 28 1985   |  |   |  |  |  |   |  |       |  |      |  |           |  |

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM-3. RETAIN PAGE 5 OF YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITH YOUR FILES AFTER DEATH. WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

100% COTTON L-UEB

DMO

WILKINSON



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours of death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE   |  |   |  | 8 5 0 1 7 2 9   |  |  |  |
|--|--|---|--|---|--|--|--|
| FOR<br>1- STATE<br>REGISTRAR   |  |   |  | CERTIFICATE OF DEATH  |  |  |  |
| 1. DECEASED NAME<br>(TYPE OR PRINT)  |  |   |  | 2a. DATE OF DEATH   |  |  |  |
| FIRST MIDDLE LAST  |  |   |  | MONTH DAY YEAR 2b. HOUR   |  |  |  |
| ANNIE YAFFE  |  |   |  | JAN 6 1985 9 <sup>45</sup> M  |  |  |  |
| 3. SEX<br>FEMALE   |  | 4. RACE<br>CAUC   |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>NOV XXX 1894  |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br>90 YRS.   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>LITHUANIA   |  | 7b. CITIZEN OF WHAT COUNTRY?<br>USA   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>BALTIMORE CITY MD  |  |
| 10. CITY OR TOWN OF DEATH<br>BALTIMORE   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>SINAI HOSPITAL |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>HOUSEWIFE   |  | 12b. KIND OF BUSINESS OR INDUSTRY<br>AT HOME   |  |
| 13a. STATE<br>MARYLAND   |  |   |  | 13b. COUNTY<br>BALTIMORE  |  | 13c. CITY OR TOWN<br>BALTIMORE   |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>LAZER YEHUDA BERMAN  |  |   |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>UNKNOWN  |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br>NO   |  | 16b. SOCIAL SECURITY NO.<br>216079917   |  | 17. INFORMANT IRVIN YAFFE ADDRESS<br>3805 GLENGYLE AVE. BALTO., MD 21215  |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) MYOCARDIAL INFARCTION<br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(b) PERFORATED DUODENAL ABBESS<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c)<br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br>5 HRS |  |   |  |   |  |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (c)   |  |   |  |   |  |  |  |
| 19a. DATE OF OPERATION<br>JAN 4, 1985  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED<br>DIVERTICULITIS  |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from Jan 3, 1985, to Jan 6, 1985, that (I) (we) last saw the deceased alive on Jan 6, 1985, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.   |  |   |  |   |  |  |  |
| 22b. SIGNATURE<br>H. MADDE   |  |   |  | DEGREE<br>MD  |  | 22c. DATE SIGNED<br>JAN 6, 1985  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>HARRY P. MADDE  |  |   |  | 22e. ADDRESS<br>SINAI HOSPITAL<br>GREENSPRING AT BELVEDERE  |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br>BURIAL   |  | 23b. DATE<br>JAN. 7, 1985   |  | 23c. NAME OF CEMETERY OR CREMATORY<br>ADATH YESHURUN  |  | 23d. LOCATION<br>BALTIMORE COUNTY MARYLAND   |  |
| 24. FUNERAL DIRECTOR<br>NAME SOL LEVINSON & BROS., INC.<br>ADDRESS 6010 REISTERSTOWN RD. BALTO., MD 21215  |  |   |  | 25a. DATE REC'D. BY REGISTRAR<br>JAN 11 1985  |  | 25b. REGISTRAR'S SIGNATURE   |  |

BP

18

3

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 5 0 1 7 3 0

FOR  
1 - STATE  
REGISTRAR

REG. NO.

|  |  |  |  |  |  |   |  |  |   |   |  |
|--|--|--|--|--|--|---|--|--|---|---|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>Dorothy Lee Yates |  |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br>1 3 85              |  |  | 2b. HOUR<br>8:50 AM   |  |  |   |   |  |
| 1. SEX<br>Female   |  | 4. RACE<br>Col.  |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>11-25-22   |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br>62   |  | 7. IF UNDER 1 YEAR<br>MONTHS DAYS HOURS MIN.<br>YRS. |   |   |  |
| 7a. BIRTHPLACE<br>(STATE OR FOREIGN COUNTRY)<br>D.C.     |  | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.A.   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Baltimore City MD.                    |  |  |   |   |  |
| 10. CITY OR TOWN OF DEATH<br>Baltimore                   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>S. L. DEATON Medical Center |  |  |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Homemaker |  | 12b. KIND OF BUSINESS OR INDUSTRY                    |   |   |  |
| 13a. COUNTY<br>BALTO.                                    |  |  | 13b. CITY OR TOWN<br>Baltimore                             |  |  | 13c. STREET ADDRESS / ZIP CODE<br>504 Benview Road 21209                      |  |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |   |  |
| 14. FATHER'S NAME<br>(TYPE OR PRINT)<br>Henry Singleton  |  |  | 15. MOTHER'S MAIDEN NAME<br>(TYPE OR PRINT)<br>Mary Powell |  |  | 16. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NOT OR UNKNOWN)<br>NO    |  |  |   | 16b. SOCIAL SECURITY NO.<br>223-42-5101         |  |
| 17. INFORMANT<br>Miss Linda Jones                        |  |  | 17. ADDRESS<br>4105 MARIDAN CT                             |  |  | 21225   |  |  |   | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH |  |

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)  
PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) Respiratory Arrest

DUE TO, OR AS A CONSEQUENCE OF

(b) Carcinoma (metastatic) to Lung

DUE TO, OR AS A CONSEQUENCE OF

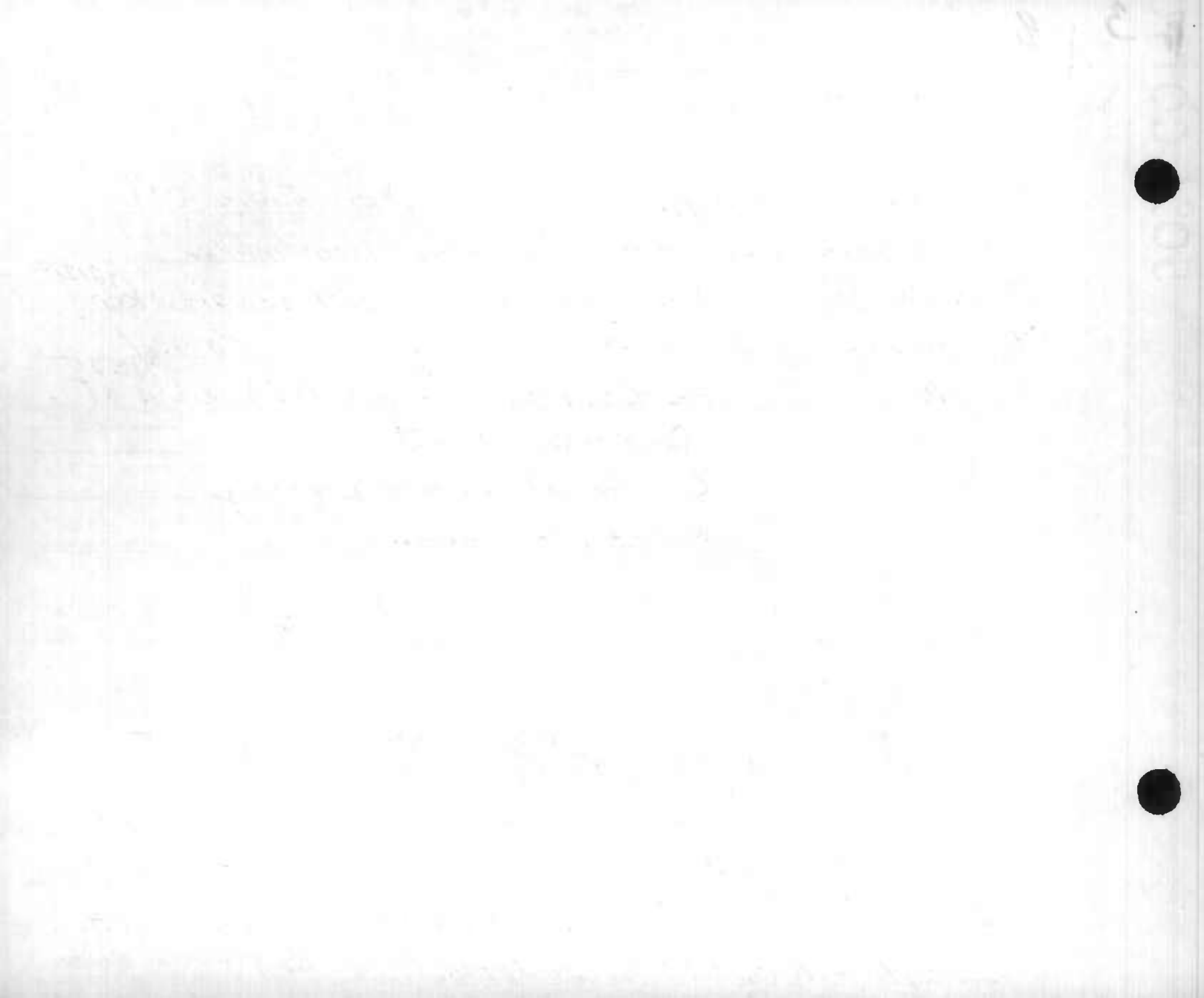
(c) Kidney Carcinoma

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a).

MEDICAL CERTIFICATION

|   |  |  |  |   |  |   |  |
|---|--|--|--|---|--|---|--|
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                       |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  | 20b. IF YES, WERE FINDINGS USED<br>IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19             |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |  |   |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK <input type="checkbox"/> ALONE <input type="checkbox"/>  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from 12/19 19 84 to 1/3 19 85, that (I) (we) last saw the deceased alive on 12/31 19 85, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. |  |  |  |   |  |   |  |
| 22b. SIGNATURE<br>H. A. Doerwaldt   |  |  |  | 22c. DATE SIGNED<br>1/3/85  |  | 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>H. A. Doerwaldt  |  |
| 22e. ADDRESS<br>611 S. Charles St. / Baltimore  |  |  |  | 22f. ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> |  | 22g. REGISTRAR'S SIGNATURE<br>John Davidson-Randall   |  |

|  |  |                     |  |   |  |   |  |
|--|--|---------------------|--|---|--|---|--|
| 23a. BURIAL, CREMATION, REMOVAL<br>(TYPE OR PRINT)<br>Burial |  | 23b. DATE<br>1-8-85 |  | 23c. NAME OF CEMETERY OR CREMATORY<br>Hampton Gardens |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Hampton VA. |  |
| 24. FUNERAL DIRECTOR<br>NAME<br>Joseph L. Russ               |  |                     |  | 24. ADDRESS<br>2222 W. North Ave                      |  | 25. DATE REC'D. BY REGISTRAR<br>JAN 4 1985                |  |
| 26. REGISTRAR'S SIGNATURE<br>John Davidson-Randall           |  |                     |  | 27. REGISTRAR'S SIGNATURE<br>John Davidson-Randall    |  |   |  |





STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

85 01731

FOR  
STATE  
REGISTRAR

REG. NO.

|   |  |  |  |   |  |   |  |
|---|--|--|--|---|--|---|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>HOWARD R. YOUNG</b>  |  |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>JANUARY 21, 1985</b> |   |  | 2b. HOUR<br><b>11:00</b> <sup>P</sup> <sub>M</sub>  |  |
| 3. SEX<br><b>male</b>   |  | 4. RACE<br><b>black</b>  |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>1 2 07</b>   |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>78</b> YRS.   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Tennessee</b>   |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>  |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore City</b> MD.                               |  |
| 10. CITY OR TOWN OF DEATH<br><b>Baltimore</b>   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>CHURCH HOME HOSPITAL</b> |  |   |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)                                |  |
| 13a. STATE<br><b>Maryland</b>   |  | 13b. COUNTY  |  | 13c. CITY OR TOWN<br><b>Baltimore</b>   |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST  |  |  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST   |  |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>NO</b>   |  | 16b. SOCIAL SECURITY NO.<br><b>413-01-4356</b>   |  | 17. INFORMANT<br>ADDRESS<br><b>Elizabeth L. Watson 2726 E. Biddle St.</b>   |  |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>CARDIORESPIRATORY ARREST</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>?</b><br>DUE TO, OR AS A CONSEQUENCE OF (c) <b>ASCVD</b> |  |  |  |   |  |   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH   |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)<br><b>ELECTROLYTE IMBALANCE?</b>  |  |  |  |   |  |   |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |   | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)  |  |   |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> AT WORK<br>NOT WHILE <input type="checkbox"/> AT WORK  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>JANUARY 18, 1985</b> to <b>JANUARY 21, 1985</b> , that (I) (we) last saw the deceased alive on <b>JANUARY 21, 1985</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.             |  |  |  |   |  |   |  |
| 22b. SIGNATURE<br><b>A. F. Nazemi M.D.</b>  |  |  |  | DEGREE<br>ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>        |  | 22c. DATE SIGNED<br><b>1/21/85</b>  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>A. F. NAZENMI</b>   |  |  |  | 22e. ADDRESS<br><b>CHURCH HOSPITAL<br/>100 NORTH BROADWAY 21231</b>   |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL<br><b>BURIAL</b>  |  | 23b. DATE<br><b>1/29/85</b>  |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Arbutus Mem. Pk.</b>   |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Arbutus, Md.</b>                               |  |
| 24. FUNERAL DIRECTOR<br>NAME ADDRESS<br><b>Wm C March F/H Inc. 1101 E North Avenue</b>  |  |  |  | 25a. DATE REC'D. BY REGISTRAR<br><b>JAN 24 1985</b>   |  |   |  |
|   |  |  |  | 25b. REGISTRAR'S SIGNATURE<br><i>J. Davidson</i>  |  |   |  |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

DAVE BROWN  
20% COTTON

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 5 0 1 7 3 2

FOR  
STATE  
REGISTRAR

REG. NO.

|   |  |  |  |   |   |  |   |   |  |
|---|--|--|--|---|---|--|---|---|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br><b>WILLIAM YOST</b>  |  |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>JANUARY 3, 1985</b>                            |   |   | 2b. HOUR<br><b>1:42</b><br>M   |   |   |  |
| 3. SEX<br><b>Male</b>   |  | 4. RACE<br><b>White</b>  |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>3-1-1917</b>   |   | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>67</b> YRS.                                    |   | 7. IF UNDER 1 YEAR<br>MONTHS DAYS HOURS MIN.<br><b>67</b>   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Baltimore</b>   |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>  |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>BALTIMORE CITY</b> MD.                    |   |   |  |
| 10. CITY OR TOWN OF DEATH<br><b>BALTIMORE</b>   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>THE JOHNS HOPKINS HOSPITAL</b> |  |   |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Guard</b>     |   | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>Johns Hopkins Un.</b>   |  |
| 13a. STATE<br><b>Maryland</b>   |  |  | 13b. COUNTY<br><b>----</b>   |   | 13c. CITY OR TOWN<br><b>Baltimore</b>   |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |   |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Charles Yost</b>   |  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Catherine Ahlondrowicz (Shaffer)</b> |   |   | 13e. STREET ADDRESS / ZIP CODE<br><b>817 S. Port St. Balto 21224</b>                 |   |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>no</b>   |  | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br><b>218-01-2081</b>  |  | 17. INFORMANT<br>ADDRESS<br><b>Cecelia Monroe 3307 Cornwall St 21222</b>  |   |  |   |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Cardiorespiratory arrest</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <b>Cancer</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <b>3 weeks</b>  |  |  |  |   |   |  |   | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH<br><b>1 HOUR</b>  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)   |  |  |  |   |   |  |   |   |  |
| 19a. DATE OF OPERATION<br><b>---</b>  |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED<br><b>---</b>                           |   |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |   | 20b. IF YES, WERE FINDINGS USED<br>IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>19</b>                             |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1, OR PART 2)<br><b>---</b> |  |   |   |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK   |  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                   |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |   |   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>01/03</b> , 19 <b>85</b> , to <b>01/03</b> , 19 <b>85</b> , that (I) (we) last saw the deceased alive on <b>01/03</b> , 19 <b>85</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |  |  |  |   |   |  |   |   |  |
| 22b. SIGNATURE<br><b>Maria T. Aristigueta MD</b> DEGREE <b>MD</b><br>ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>   |  |  |  |   |   | 22c. DATE SIGNED<br><b>01/03/85</b>  |   |   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>Maria T. Aristigueta MD</b>   |  |  |  |   | 22e. ADDRESS<br><b>Johns Hopkins Hospital</b>   |  |   |   |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>Burial</b>   |  |  | 23b. DATE<br><b>Jan. 5 1985</b>  |   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Oak Lawn Cemetery</b>                                |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Baltimore Md.</b>                              |   |  |
| 24. FUNERAL DIRECTOR<br>NAME ADDRESS<br><b>Lilly &amp; Zeiler, Inc. 1901 Eastern Ave.</b>   |  |  |  |   | 25a. DATE REC'D. BY REGISTRAR<br><b>JAN 7 1985</b>  |  |   |   |  |
|   |  |  |  |   | 25b. REGISTRAR'S SIGNATURE<br><b>Julia Davidson-Randall</b>                                   |  |   |   |  |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed by the funeral director with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic cause, the medical examiner must be notified.

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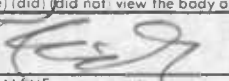
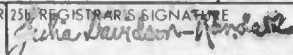
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STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

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FOR  
STATE  
REGISTRAR

REG. NO.

|  |  |   |  |  |  |
|--|--|---|--|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>George Adam Zametzer  |  |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br>January 31, 1985                              |  | 2b. HOUR<br>1:19P M  |
| 3 SEX<br>Male  | 4. RACE<br>White   | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>3 14 1905   |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br>79 YRS.   | IF UNDER 1 YEAR<br>MONTHS DAYS HOURS MIN.  |
| 7a. BIRTHPLACE<br>(STATE OR FOREIGN COUNTRY)<br>Maryland   | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.A.   | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Baltimore City MD.   |  |
| 10. CITY OR TOWN OF DEATH<br>Baltimore   | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>Church Hospital Corporation |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Mechanic--Martin |  | 12b. KIND OF BUSINESS OR INDUSTRY<br>Marietta  |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE<br>Maryland  |  | 13b. COUNTY<br>Baltimore  | 13c. CITY OR TOWN<br>Dundalk   | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                    |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>Adam Zametzer  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Laura C. Reed  |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br>No   |  | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br>216-09-0844  |  | 17. INFORMANT<br>ADDRESS<br>Elsie Zametzer Same as 13e   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY<br>IMMEDIATE CAUSE (a) <u>CARDIAC ARRYTHMIA</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost } (b) <u>CONGESTIVE HEART FAILURE</u><br>DUE TO, OR AS A CONSEQUENCE OF (c) |  |   |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH   |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: (a)<br><u>CVA: RIGHT LOWER LOBE PNEUMONIA: CORONARY ARTERY DISEASE</u>  |  |   |  |  |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                               | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)                                      |  |
| 21d. INJURY OCCURRED<br>AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>January 23, 1985</u> to <u>January 31, 1985</u> that I (we) last saw the deceased alive on <u>January 31, 1985</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.                      |  |   |  |  |  |
| 22b. SIGNATURE<br>  |  | DEGREE<br>ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>                   |  | 22c. DATE SIGNED   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>S.S. Dang, M.D.   |  | 22e. ADDRESS<br>CHURCH HOSPITAL<br>100 N. BROADWAY, BALTO., MD 21231  |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br>Burial   |  | 23b. DATE<br>2/4/1985   |  | 23c. NAME OF CEMETERY OR CREMATORY<br>Oak Lawn   |  |
| 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Baltimore Maryland   |  | 23e. DATE REC'D. BY REGISTRAR<br>FEB 6 1985   |  |  |  |
| 24. FUNERAL DIRECTOR<br>NAME<br>Duda-Ruck, Inc.  |  | ADDRESS<br>7922 Wise Avenue Dundalk, MD. 21222  |  | 25. REGISTRAR'S SIGNATURE<br> |  |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be kept with the 7. Death certificate with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked as item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH  |  |  |  |   |  |   |  |   |  |
|---|--|--|--|---|--|---|--|---|--|
| Item 13e per phone 1/25/85 dad<br>1- FOR STATE REGISTRAR  |  |  |  |   |  |   |  |   |  |
| 1. DECEASED NAME (TYPE OR PRINT)<br><b>Henry ZIMMERMAN</b>  |  |  |  |   |  | 2a. DATE OF DEATH<br><b>January 14, 1985</b>  |  | 2b. HOUR<br><b>8:55P M</b>  |  |
| 3. SEX<br><b>Male</b>   |  | 4. RACE<br><b>White</b>  |  | 5. DATE OF BIRTH<br><b>January 11, 1902</b>   |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>83</b>  |  | IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS.<br>HOURS MIN.  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Maryland</b>  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>  |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore City</b> MD.                               |  |   |  |
| 10. CITY OR TOWN OF DEATH<br><b>Baltimore</b>   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Maryland General Hospital</b> |  |   |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Retired Carpenter</b>       |  | 12b. KIND OF BUSINESS OR INDUSTRY   |  |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE<br><b>Maryland</b>   |  | 13b. COUNTY<br><b>Baltimore</b>  |  | 13c. CITY OR TOWN<br><b>Baltimore</b>   |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 13e. STREET ADDRESS / ZIP CODE<br><b>21201 Maryland Ave. &amp; Charles St.</b>  |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Alfred Zimmerman</b>   |  |  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Julia Kloss</b>   |  |   |  |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)<br><b>No</b>  |  | 16b. SOCIAL SECURITY NO.<br><b>216-32-4092</b>   |  | 17. INFORMANT <b>Mr Louis A Zimmerman</b><br><del>XXXXXXXXXX</del> ADDRESS<br><b>6 Dunkirk Rd 21212</b>   |  |   |  |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Bronchopneumonia, severe</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(b) <b>Pyelonephritis, chronic.</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c)   |  |  |  |   |  |   |  |   |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)   |  |  |  |   |  |   |  |   |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  |   |  | 20a. AUTOPSY?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>            |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |  |   |  |   |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |   |  |   |  |
| 22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <b>January 2, 1985</b> to <b>January 14, 1985</b> , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on <b>January 14, 1985</b> , and that in <input checked="" type="checkbox"/> (our) opinion death occurred on the date and hour and from the causes stated above, <input checked="" type="checkbox"/> (we) (did) (did not) view the body after death. |  |  |  |   |  |   |  |   |  |
| 22b. SIGNATURE<br><b>Parmanderjeet Sandhu</b>   |  |  |  | DEGREE<br>ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>        |  |   |  | 22c. DATE SIGNED<br><b>1/15/85</b>  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>Parmanderjeet Sandhu, M.D.</b>  |  |  |  | 22e. ADDRESS<br><b>c/o Maryland general Hospital</b>  |  |   |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>Burial</b>  |  | 23b. DATE<br><b>1/18/85</b>  |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Greenmount</b>   |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Baltimore, Maryland</b>                        |  |   |  |
| 24. FUNERAL DIRECTOR<br>NAME ADDRESS<br><b>Leonard J Ruck Inc. Baltimore, Maryland</b>  |  |  |  | 25a. DATE OF DEATH BY REGISTRATION<br><b>JAN 18 1985</b>  |  |   |  |   |  |

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